DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (HHS) is charged with protecting the health of all Americans. This includes supporting medical research, promoting wellness, preventing and controlling disease, ensuring the safety of drugs and medical devices, and providing health care and related services.

The budget of HHS "represents almost a quarter of all federal outlays, and it administers more grant dollars than all other federal agencies combined. HHS' Medicare program is the nation's largest health insurer, handling more than 1 billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans."[1] HHS is also involved in other activities such as assisting with the management of wastewater treatment facilities[2] as well as doing house work and shopping for older Americans.[3]

HHS is made up of many diverse agencies, including the Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, the Substance Abuse and Mental Health Services Administration, Office of Global Health Affairs, and the Office of the Surgeon General, which includes the 6,500-member Commissioned Corps of the U.S. Public Health Service.

Improving Management of Funds and Resources

The entire annual HHS budget exceeds $889 billion. This mammoth budget has proven difficult to properly manage. From paying health care claims submitted for dead patients and prisoners to bonuses to nursing homes for substandard care to excess travel costs, mismanagement at HHS is costing taxpayers more than one billion dollars *every* week.

In 2010, the Office of Management and Budget (OMB) designated five HHS programs as "high-error" based on the agencies' annual performance and financial reports. In just two of these

[1] "About HHS," HHS website, accessed June 30, 2011; http://www.hhs.gov/about/ .
[2] "TERMINATION: RURAL COMMUNITY FACILITIES," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 61; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .
[3] Administration on Aging Annual Report 2008, Page 7; http://www.aoa.gov/AoARoot/Program_Results/docs/2008/AOA_2008AnnualReport.pdf .

programs, Medicare Fee-for-Service and Medicaid, HHS made $56.8 billion of improper payments.[4] These "improper payments" include millions of dollars of Medicare claims submitted under the names of dead doctors[5] and ordered for medical services for dead patients.[6] "Medicare fraud—estimated now to total about $60 billion a year—has become one of, if not the most profitable, crimes in America," CBS News recently reported, which raises "troubling questions about our government's ability to manage a medical bureaucracy."[7]

Mismanagement at HHS is costing taxpayers more than one billion dollars *every week*.

Fraud is not the only cause of wasted federal health care dollars. For instance, the Centers for Medicare and Medicaid Services awarded more than $312 million a year in bonuses to nursing homes with past violations of basic health-and-safety standards that provided below-average care.[8]

There are plenty of other areas where HHS spending is simply excessive. HHS spent $215 million on travel, including the cost of rental cars, hotels and airline tickets, in 2008.[9] The Department spent at least $349 million on conferences and meetings over the last decade.[10]

Millions of dollars of HHS equipment disappears every year. Over 5,000 items worth $15.8 million, including laptop computers, all-terrain vehicles, tractors, pickup trucks, and medical devices, were lost or stolen by employees of HHS' Indian Health Service between 2004 and 2007.[11] Investigators blamed management failures and weak leadership for the problems, yet the

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[4] Statement by Dr. David Acheson, Associate Commissioner on Foods at the Food and Drug Administration of the U.S. Department of Health and Human Services on Improper Payments in Government Agencies and Departments before the U.S. House of Representatives Committee on Appropriations' Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, May 11, 2011; http://www.hhs.gov/asl/testify/2011/03/t20110317e.html .

[5] Jane Zhang, "Medicare Ignored Its Claims Policy, Audit Says," The Wall Street Journal, August 26, 2008; http://online.wsj.com/article/SB121971017492971293.html .

[6] "Doctor Pleads Guilty to Billing Medicare and Medicaid for Counseling Sessions with Dead Patients; Dr. Williams Claimed $2 Million in Phony Health Treatments, Saying It Was Group Therapy," U.S. Attorney's Office, Northern District of Georgia, FBI website, June 6, 2011; http://www.fbi.gov/atlanta/press-releases/2011/doctor-pleads-guilty-to-billing-medicare-and-medicaid-for-counseling-sessions-with-dead-patients

[7] "Medicare Fraud: A $60 Billion Crime," CBS News, September 5, 2010; http://www.cbsnews.com/stories/2009/10/23/60minutes/main5414390.shtml .

[8] Clark Kauffman, "Nursing homes across the U.S. receive bonuses despite violations," Des Moines Register (Iowa), November 9, 2008; http://www.desmoinesregister.com/article/20081109/NEWS10/811090341/-1/SPORTS09 .

[9] Staff estimate based on OMB numbers.

[10] David Freddoso, "Government conference spending gone wild!," Washington Examiner, August 29, 2009; http://www.washingtonexaminer.com/opinion/blogs/beltway-confidential/Government-conference-spending-gone-wild-54832242.html .

[11] "INDIAN HEALTH SERVICE: IHS Mismanagement Led to Millions of Dollars in Lost or Stolen Property (GAO-08-72)," Government Accountability Office, June 2008; http://www.gao.gov/new.items/d08727.pdf .

official in charge of IHS' property group still received a $13,000 bonus award in December 2008.[12]

The Department ends every year with billions of dollars in excess funds. HHS is expected to end 2011 with more than $210 billion in unspent funds. Over $40 billion of that amount is unobligated. The Department is expected to end 2012 with an even greater amount of unobligated money.[13]

One way the Department could clean up their act and save taxpayer dollars is simply through complying with existing federal law. The nonpartisan analysis of an audit conducted by Ernst & Young on the balance sheets of the Department of Health and Human Services for FY2010, was included in HHS's FY 2010 Agency Financial Report, dated November 15, 2010. The audit revealed concerning conclusions; among the many findings were the following:[14]

- HHS is not in compliance with federal financial management law. According to the HHS Inspector General's review of Ernst & Young's financial audit of HHS, "HHS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996."
- Nearly $2 billion taxpayer dollars are stuck in limbo. "As of September 30, 2010, the audit identified approximately 102,500 transactions totaling an approximate $1.8 billion that were more than 2 years old without activity."
- Nearly $800 million dollars "could not be explained" differing between HHS' records and treasury department records. "Based on our review and discussions with management, we noted differences of $794 million that could not be explained."
- Some processes and procedural manuals have not been updated since the 1980s. "HHS's formalized policies and procedures are out of date and may be inconsistent with actual processes taking place….For example, we noted that certain policies and procedures, including certain accrual processes, had not been updated since the mid-1980s."
- Current HHS personnel need training to "complete their day-to-day responsibilities." "Further, we noted additional training on the financial systems was needed to enable HHS personnel in their ability to access needed information from the system to complete their day-to-day responsibilities - including the preparation of reconciliations, research of differences noted, and the ability to identify and clear older "stale" transactions dating back several years."

Repeal Damaging Provisions of Wrong-Headed, Controversial Health Care Law

Before it became law, supporters argued the federal health care overhaul would become more popular after it passed Congress. However, more than a year later, most Americans remain opposed to the law and still concerned about its impact on their family, budget, and health care

[12] Robert Brodsky, "Watchdog: Indian Health Service continues to mismanage property," Government Executive, May 26, 2009; http://www.govexec.com/story_page.cfm?articleid=42809&dcn=todaysnews .
[13] "Balances of Budget Authority Fiscal Year 2012," Budget of the U.S. Government, Office of Management and Budget, page 8, accessed June 16, 2011; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/balances.pdf .
[14] Summary of Findings of the Ernst & Young audit, Office of Senator Tom Coburn, M.D., http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=6a04c50e-72c7-477e-ac37-cbae0f575d10

choices.[15] The proposal outlines some of the most damaging impacts that are avoided through repeal.

Repeal prevents Americans from losing the health insurance plan they like. Proponents of the health care overhaul often pledged that health reform would allow Americans who liked their current health plan to keep it. But In June, the U.S. Department of Health and Human Services issued rules limiting changes employers can make to health insurance plans, and still be considered to be "grandfathered" – or exempt from many of the new mandates in the law. Under the Department's own estimates, *more than half* of companies may have to give up their current health coverage because of the new law by 2013.[16] And, in their estimate, the Administration predicts that *eight in 10* small businesses could lose their current health plans.[17]

Repeal prevents the economy from losing nearly 800,000 jobs. The nonpartisan Congressional Budget Office (CBO) released an analysis of the "effects of recent health care legislation on labor markets."[18] The CBO's findings painted a troubling picture. The massive Medicaid expansion will "encourage some people to work fewer hours or to withdraw from the labor market."[19] Additionally, phasing out the subsidies to buy expensive insurance "will effectively increase marginal tax rates, which will also discourage work."[20] CBO said "other provisions in the legislation are also likely to diminish people's incentives to work." [21] The CBO "estimates that the legislation, on net, will reduce the amount of labor used in the economy by a small amount—roughly half a percent—primarily by reducing the amount of labor that workers choose to supply", which is more than 788,470 employees.[22] Another independent

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[15] http://www.huffingtonpost.com/2009/07/30/healthplan_n_725503.html

[16] U.S. Department of Health and Human Services, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," June 17, 2010. http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf

[17] U.S. Department of Health and Human Services, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," June 17, 2010. http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480b03a90&disposition=attachment&contentType=pdf

[18] Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, page 66-67 of PDF. http://cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf

[19] Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, page 66-67 of PDF. http://cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf

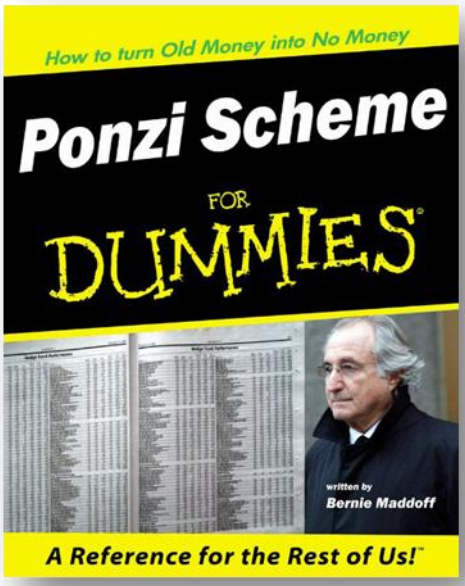
[20] Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, page 66-67 of PDF. http://cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf

[21] Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, page 66-67 of PDF. http://cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf

[22] Congressional Budget Office, "The Budget and Economic Outlook: An Update," August 2010, page 66-67 of PDF. http://cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf . According to a U.S. Department of Labor estimate, the 2010 labor force is estimated to comprise 157,695,000 workers. Half of one of percent of our nation's 157 million work force equals 788,475 workers. Lee, Marlene and Mather, Mark. "U.S. Labor Force Trends," Population Bulletin, Vol. 63, No. 2, June 2008. http://www.prb.org/pdf08/63.2uslabor.pdf

estimate predicted the overhaul will "destroy a total of 120,000 to 700,000 jobs by 2019."[23] This is a huge number of future jobs and future workers that will be effectively sidelined because of the health reform legislation. With more than 14 million Americans out of work today, we cannot afford to lose more jobs.

Repeals the panel of unelected, unaccountable Medicare czars that will slash reimbursements to physicians, threatening access to care for seniors. The controversial health care overhaul created the Independent Payment Advisory Board (IPAB) –a panel of unelected bureaucrats who will be politically-appointed and charged with developing proposals to reduce the per capita rate of growth in Medicare spending. Under the law, HHS is forced to implement the panel's proposals automatically unless Congress intervenes with similar cuts. There are virtually no checks on the panel, since its members are not answerable to voters and its recommendations cannot be challenged in court. Many of these unelected technocrats are likely to have political connections to powerful politicians, but not all of them are required to be physicians. Because the panel is barred from examining common-sense changes like Medicare beneficiary premiums, cost-sharing, or benefit design, many expect that in efforts to control spending, the panel will limit patient access to medical care by slashing provider reimbursements to a point that doctors cannot afford to see Medicare patients.



Repeals a provision that could force taxpayers to bail out a "Ponzi scheme" program. Section 8002 created the Community Living Assistance Services and Supports program (CLASS), a "voluntary federal program for long-term care insurance that would be administered by the Secretary of Health and Human Services (HHS)."[24] Unlike traditional health insurance that covers medical benefits, long-term insurance generally covers services that assist individuals in their day-to-day activities of life, such as bathing, eating, or dressing. While the purpose sounds good, the CLASS program is misguided policy. The financial structure of the program is so shaky it could require a taxpayer-funded bailout while saddling taxpayers with mountains of debt. According to the Congressional Budget Office (CBO), this provision could "add to budget deficits …. in succeeding decades – by amounts on the order of tens of billions of dollars for each 10-year period."[25] The problems with the structure of the program are so systemic that the American Academy of Actuaries concluded "an actuarially sound

[23] Tuerck, David, et. al. "Killing Jobs through National Health Care Reform," Beacon Hill Institute Policy Study, March 2010. http://www.atr.org/userfiles/BHI%20Health%20Care%20Reform%20as%20Job%20Killer(7).pdf

[24] Congressional Budget Office, "Letter to The Honorable Tom Harkin, Chairman of the U.S. Senate Committee on Health, Education, Labor, and Pensions," November 25, 2009.http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf

[25] Congressional Budget Office, "Letter to The Honorable Tom Harkin, Chairman of the U.S. Senate Committee on Health, Education, Labor, and Pensions," November 25, 2009. http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf

program may not be possible to achieve" despite changes that might be sought.[26] The CLASS program would effectively self-destruct. In fact, the financial structure for this new provision is so untenable that one Senator who voted for the health care overhaul called it "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."[27]

Repeals policies that increase health insurance costs. Unfortunately, the overhaul that passed Congress last year did not represent the *real* health reform Americans want and need. The new law focused on some of the symptoms in our health care system, but failed to address the underlying disease. For a majority of Americans, the cost of health coverage is their primary concern.[28] For too many, cost is the access problem. Unfortunately, the new law increases costs to patients, consumers, and taxpayers, while exacerbating many existing problems in health care. Independent experts have found that the new health law will increase the cost of health insurance and health care services. According to the nonpartisan Congressional Budget Office (CBO), premiums for millions of American families in 2016 will be 10-13 percent higher than they otherwise would be. [29] This represents a $2100 increase per family, compared with the status quo.[30] And, according to a memo from the Actuary of the Centers for Medicare and Medicaid Services, the medical device and pharmaceutical drugs fees and the health insurance excise tax will "generally be passed through to health consumers in the form of higher drugs and device prices and higher insurance premiums, with an associated increase in overall national health expenditures…."[31] The JCT has also confirmed that many of the new taxes included in the health care reform law will be passed on directly to consumers, including the $60 billion tax on health plans, the $20 billion tax on medical devices, and the $27 billion tax on prescription drugs.[32]

[26] American Academy of Actuaries, "Community Living Assistance Services and Supports Act," Critical Issues in Health Reform, November 2009. http://www.actuary.org/pdf/health/class_nov09.pdf

[27] Lori Montgomery, "Proposed Long-Term Health Insurance Program Raises Questions," The Washington Post, October 27, 2009. http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html.

[28] U.S. Department of Health and Human Services, "America Speaks on Health Reform: Report on Health Care Community Discussions," page 101, March 2009, http://www.healthreform.gov/reports/hccd/report_on_communitydiscussions.pdf.

[29] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " page 4, November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[30] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, " page 4, November 30, 2009, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf. On page 6: "Average premiums per policy in the non-group market in 2016 would be roughly $5,800 for single policies and $15,200 for family policies under the proposal, compared with roughly $5,500 for single policies and $13,100 for family policies under current law."

[31] Foster, Richard, Chief Actuary for the Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfefd0.

5 Federal Register, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient

[32] 23Joint Committee on Taxation, "Technical Explanation of the Revenue Provisions of the 'Reconciliation Act of 2010,' as Amended, In Combination with the 'Patient Protection and Affordable Care Act,'" March 21, 2010, http://www.jct.gov/publications.html?func=startdown&id=3673.

Repeals mandates that crush states with $120 billion in additional costs. Before the passage of the health overhaul, the Congressional Budget Office (CBO) estimated that the "state spending on Medicaid" would increase by tens of billions of dollars "as a result of the coverage provisions."[33] In pegging the costs to states, they noted that "under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and the Children's Health Insurance Program."[34] But now that the health overhaul has been signed into law, states are stuck with federal mandates buried in the law that dictate many of the operations of the state-level Medicaid programs. So how big are the costs state taxpayers must absorb from the massive Medicaid expansion or other mandates? A report tallying estimates that several states produced calculating the costs to their states pegged the new cost burden from the health law at $118 billion over a decade.[35] These costs to state governments and taxpayers may not have been fully calculated by CBO, but they nonetheless are real costs that must be borne by American taxpayers. Unless the cost-increasing mandates are repealed, governors and legislatures must effectively decide what education programs or public infrastructure works will be cut even further. These massive federal mandates that lead to skyrocketing state costs should be repealed.

Repeals requirement that makes it illegal not to have health insurance. Starting in 2014, it will be illegal for most Americans not to purchase health insurance. Never before has the federal government passed a law requiring Americans to purchase any commodity. But, under the new health law, Americans face a choice between buying government-dictated insurance or breaking federal law.

Repeals a massive Medicaid expansion that enrolls up to 25 million Americans in government-run program that delays and denies care. Medicaid is a federal-state government health program that is already denying patients access to care and yielding poorer heath outcomes. The new health law will force at least half of currently uninsured Americans –16 million people – into Medicaid. And according to the Chief Actuary of the Centers for Medicare and Medicaid (CMS), the number of Americans forced into this substandard medical program could climb as high as 25 million.[36] A 2002 government survey found that "approximately 40% of physicians restricted access for Medicaid patients," because payment rates are so low. [37] As former CMS official Dr. Scott Gottlieb explained, "only about half of

[33] Congressional Budget Office, "Letter to the Honorable Harry Reid, U.S. Senate Majority Leader," March 11, 2010. http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf . CBO budget
[34] Congressional Budget Office, "Letter to the Honorable Harry Reid, U.S. Senate Majority Leader," March 11, 2010. http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf
[35] Joint Congressional Report, "Medicaid Expansion in the New Health Law: Costs to the States," http://thehill.com/images/stories/blogs/medicaidcost.pdf
[36] Richard S. Foster, F.S.A, Chief Actuary, Centers for Medicare & Medicaid Services. "The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures," Testimony before the House Committee on the Budget, January 26, 2011. http://budget.house.gov/UploadedFiles/fostertestimony1262011.pdf
[37] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*, January 8, 2009, http://online.wsj.com/article/SB123137487987962873.html.

U.S. physicians accept new Medicaid patients, compared with more than 70% who accept new Medicare patients."[38] With such restrictions on access to care, patients on Medicaid experience higher infant mortality rates (IMR). The nonpartisan CRS conducted a data analysis of the IMR in four states.[39] In one state with an IMR higher than the U.S. average, researchers found that "births covered by Medicaid had worse outcomes when compared to births covered by private insurance…. When compared to private insurance, Medicaid mothers received less prenatal care and had nearly twice as high rate of infant mortality."[40] In addition to poorer health outcomes, Medicaid patients have a limited selection of health care providers. According to a 2009 poll of 110,000 practicing physicians who were asked about insurance market reforms, only one in 4 responding physicians identified enrolling the uninsured in Medicaid as the best change for patients and physicians, so all Americans can have health insurance and insurance companies are held accountable.[41] Nearly half of physicians in the same poll said government health programs, including Medicaid, are ineffective or very ineffective at responding to the individual needs of patients and empowering physicians and providers to provide quality care. About two-thirds of physicians said increased federal control over health care would decrease their ability to provide high quality care to patients.[42]

Repeals provisions of the law that would grow bureaucracies at the IRS and Department of Health and Human Services' by up to $20 billion. According to the nonpartisan Congressional Budget Office's estimates, repeal of the health care legislation would "probably reduce the appropriations needed by the Internal Revenue Service by between $5 billion and $10 billion over 10 years, and CBO said "similar savings would accrue to the Department of Health and Human Services."[43]

Reducing Excessive Overhead Costs and Unnecessary Bureaucracy

HHS could save tens of billions of dollars every year by reducing improper payments, modernizing their systems, controlling unnecessary costs, and improving management of resources.

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[38] Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*, January 8, 2009, http://online.wsj.com/article/SB123137487987962873.html.
[39] Heisler, Elayne J., "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.
[40] Heisler, Elayne J., "Infant Mortality Rates," Congressional Research Service, October 14, 2009, http://coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=5d0b18f4-af13-4d84-85fd-b44c58895933.
[41] Poll Results, "From Sen. Coburn, MD: Your input on Insurance Market Reforms," February 8, 2010, http://www.sermo.com/results/posts/41286_from_senator_coburn_md_your_input_on_insurance_reform/survey_results.html.
[42] Poll Results, "From Sen. Coburn, MD: Your input on Insurance Market Reforms," February 8, 2010, http://www.sermo.com/results/posts/41286_from_senator_coburn_md_your_input_on_insurance_reform/survey_results.html.
[43] Congressional Budget Office, "Letter to the Honorable John Boehner, U.S. Speaker of the House," February 18, 2011. http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf

There are a number of cost controls the Department could implement to save hundreds of millions of dollars without reducing or compromising services.

President Obama has proposed cutting $200 million in HHS' administrative budget next year. The Office of Management and Budget (OMB) notes "the Federal Government spends extensive amounts on services or products that may be characterized as administrative or overhead. Over the past five years, spending on certain of these activities has grown substantially." The Obama Administration has directed each agency to cut unnecessary spending and, according to OMB, "agencies are busy putting in place the processes and policies during 2011 that will enable them to realize these savings in 2012."[44]

In addition to the savings recommended by the President, there are a number of specific areas within the departmental management budget of HHS where spending should be reduced.

The office set to receive the greatest proportional growth is the Assistant Secretary for Public Affairs (ASPA). ASPA is essentially the public relations department within HHS that prepares op-eds, speeches, statements, and media outreach materials, coordinates media appearances for Department officials, responds to media requests, manages the HHS web site, and develops media strategies.

ASPA has been funded at $4.8 million in 2010 and 2011 and has 24 full time employees this year. The 2012 budget proposed by HHS for the office is $19.9 million with the staff size expected to nearly double to 46 full time employees.[45] At a time when actual services are being reduced, it is not appropriate for the public relations budget to increase, especially by such an obscene amount. The ASPA budget should be reduced to $4 million.

[44] "REDUCTION: ADMINISTRATIVE EFFICIENCY INITIATIVE," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 88; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[45] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 14; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .

At the same time many services for Americans are being reduced, HHS is seeking to double its public relations staff and dramatically increase its PR budget from $4.8 million to $19.9 million next year.[46]

The office of the Assistant Secretary for Legislation (ASL) is also set to receive a hefty budget increase. The ASL is the "principal advocate before Congress for the Administration's health and human services initiatives" and serves as chief HHS legislative liaison and principal advisor to the Secretary and the Department on Congressional activities."[47] The ASLA budget has been funded at $3.2 million in 2010 and 2011 but is proposed to be $4.9 million in 2012. The Department claims the increase is necessary for "responding to the increased congressional inquiries related to Health Reform as a result of the implementation and review of the legislation." This is an excessive amount and, while allowing for a modest increase, the total amount should be capped at $3.5 million.

HHS departmental management will spend $5,330,000 on printing and reproduction this year. This is a dramatic increase from the $1,794,000 spent in 2010.[48] With more and more information available in electronic format, such an increase in costs is not justifiable and this is an area where costs should be declining, but HHS has projected spending more than $5 million again in 2012. Printing and reproduction costs for departmental management should be capped at $1.8 million.

Departmental management spending on travel increased 40 percent in a single year, from $5 million in 2010 to $7 million in 2011.[49] The Department expects to spend $7 million again in 2012, but this amount should be capped at $5 million.

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[46] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 14; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .
[47] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 41; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .
[48] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 15; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .
[49] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 15; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .

Equipment expenditures by the departmental management is projected to more than double from $2.9 million spent in 2010 to more than $6 million expected to be spent in 2012. This amount should be capped at $3.5 million,[50] which is still a generous 20 percent increase.

Supplies and materials costs have jumped from $1.9 million in 2010 to $2.9 million in 2011 and are projected to reach nearly $8 million in 2012.[51] These expenditures should be capped at $2.5 million.

Administration for Children and Families

The Administration for Children and Families (ACF) is responsible for federal programs intended to "promote the economic and social well-being of families, children, individuals, and communities."[52]

The Job Opportunities for Low-Income Individuals program (JOLI) provides grants to foster the economic self-sufficiency of the targeted populations by creating new jobs for low-income individuals.[53] Including JOLI, the federal government administers at least 80 economic development programs and 47 job training programs. President Obama is proposing eliminating JOLI because "the program is duplicative of other job training and low-income support programs" and "has never been evaluated, nor does it have performance measures."[54]

The Rural Community Facilities program provides "training and technical assistance to low-income rural communities in developing and managing affordable, safe water and wastewater treatment facilities."[55] According to the Office of Management and Budget, this program "is duplicative of other wastewater treatment programs in the Department of Agriculture (USDA) and the Environmental Protection Agency (EPA). These agencies have the expertise to manage water treatment programs in rural communities, whereas the Administration for Children and Families administers social service programs." OMB points out "ACF staff does not have the expertise to effectively and efficiently administer a water treatment program." President Obama has proposed the Rural Community Facilities program be eliminated and Congress should end the program. [56]

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[50] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 15; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .
[51] "Department of Health and Human Services Fiscal Year 2012 Justification of Estimates for Appropriations Committees," Department of Health and Human Services, page 15; http://www.hhs.gov/about/FY2012budget/gdm_cj_fy2012.pdf .
[52] The Administration for Children and Families website, accessed July 6, 2011; http://www.acf.hhs.gov/acf_about.html .
[53] "TERMINATION: CHILDREN AND FAMILIES SERVICES' JOB DEMONSTRATION PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 15; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .
[54] "TERMINATION: CHILDREN AND FAMILIES SERVICES' JOB DEMONSTRATION PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 15; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .
[55] "FACT SHEET: Rural Community Development," ACF website, accessed June 27, 2011; http://www.acf.hhs.gov/programs/ocs/rf/fact_sheet.html .
[56] "TERMINATION: RURAL COMMUNITY FACILITIES," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 61; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

The Administration for Children and Families at the Department of Health and Human Services "does not have the expertise to effectively and efficiently administer a water treatment program," according to the Office of Management and Budget. Yet, the agency runs a program that assists with the development and management of wastewater treatment facilities.[57]

The Community Economic Development program (CED) provides federal grants to community development corporations for the purpose of supporting "employment and commercial development projects designed to provide economic self-sufficiency for low-income residents and their communities."[58] This mission of this program, which has an annual budget of $36 million, is duplicative of 180 other government development programs, has a very low success rate, and does not fit within the mission or expertise of the Department of Health and Human Services.[59] The Office of Management and Budget notes "economic development is not the primary focus of the Department of Health and Human Services, and recent evidence suggests mixed results for the CED program. According to HHS's most recent report to the Congress, only one out of five funded projects within the CED program were successful. Three out of five projects were incomplete. One out of five projects was unsuccessful, having been unable to finalize the necessary activities needed to complete a project. Although grants are competitive, many of the same grantees receive funding year after year."[60] Including CED, more than a dozen different federal agencies administer at least 180 economic development programs costing

[57] "TERMINATION: RURAL COMMUNITY FACILITIES," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 61; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[58] "FACT SHEET: Community Economic Development," ACF website, accessed July 1, 2011; http://www.acf.hhs.gov/programs/ocs/ced/fact_sheet.html .

[59] "Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue", Government Accountability Office, March 2011, http://www.gao.gov/new.items/d11318sp.pdf

[60] "REDUCTION: COMMUNITY ECONOMIC DEVELOPMENT PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 101; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

taxpayers about $188 billion annually.[61] President Obama has proposed cutting the CED budget by $16 million.[62] Due to its lack of success, duplicative nature, and inappropriate placement within HHS, CED should be eliminated. Any ongoing grants projects, which have three to five years to complete implementation, and have demonstrated success, shall continue to receive the remaining funding promised as part of the original grant award.

Only one out of five projects funded by the Community Economic Development program were successful. The program duplicates the mission of at least 180 other federal programs.

The Community Service Block Grant (CSBG) program is another grant program providing federal funds to States and territories intended to pay for a variety of services for low-income populations. "Typically, States fund these services by making sub-grants" to other organizations.[63] This, of course, has allowed some grant recipients to award no-bid contracts for pet projects that have little, if anything, to do with aiding the poor. A recent audit in Detroit, for example, found much of a $1.1 million Community Service Block Grant the city received to provide services to low income residents was instead wasted on new furniture for city employees and extra pay for contractors.[64] President Obama's proposed budget calls for cutting CSBG funding by 50 percent, noting CSBG provides funding for the important work of Community Action Agencies, but does not hold these agencies accountable for outcomes.[65] Because this program duplicates other federal community development and low income assistance programs and does not provide sufficient accountability or demonstrable results, it should be eliminated.

President Obama has called for the termination of the *Voting Access for Individuals with Disabilities grant program* which promotes access and participation of individuals with disabilities in elections. The Office of Management and Budget notes "States have balances of over $35 million in unexpended funds from prior year appropriations for this program" which

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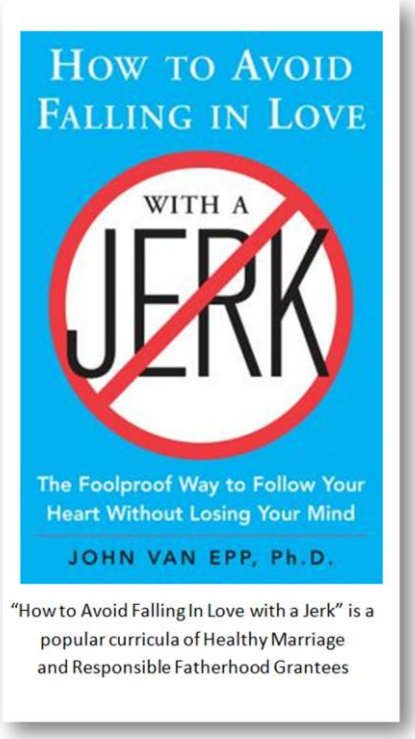
[61] Drabenstott, Mark, "A Review of the Federal Role in Regional Economic Development," Center for the Study of Rural America & Federal Reserve Bank of Kansas City, May 2005.
[62] "REDUCTION: COMMUNITY ECONOMIC DEVELOPMENT PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 101; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .
[63] "Community Services Block Grant (CSBG)," ACF website, accessed July 5, 2011; http://www.acf.hhs.gov/programs/fbci/progs/fbci_csbg.html
[64] Darren Nichols, "Detroit's block grant program in disarray," The Detroit News, May 18. 2011; http://detnews.com/article/20110518/METRO01/105180371/Detroit%E2%80%99s-block-grant-program-in-disarray .
[65] "THE BUDGET: DEPARTMENT OF HEALTH AND HUMAN SERVICES, FISCAL YEAR 2012," White House Office of Management and Budget website, accessed July 5, 2011, page 84; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/health.pdf .

can still be used to support this effort next year should resources be needed.[66] This unspent amount is more than twice the size of the program's $17 million annual budget. Because the program's funding has apparently exceeded needs, "almost $1 million in funds lapsed and was returned to the Treasury" at the beginning of the year, according to OMB.[67]

ACF's *Healthy Marriage Promotion and Responsible Fatherhood Grants* is not an essential program taxpayers should fund. Marriage is the foundation of our society and a sacred institution that should be revered and supported. The federal government can honor, respect and promote the value of marriage in many ways. However, government programs touting marriage are not essential to achieve these noble goals. Rather, the best way for government to promote marriage is to simply not undermine or devalue the institution and respect the rights of parents to care for their children. The program attempts to promote marriage and responsible fatherhood with public advertising campaigns, education in high schools, and marriage counseling for engaged and married couples.[68]



"How to Avoid Falling In Love with a Jerk" is a popular curricula of Healthy Marriage and Responsible Fatherhood Grantees

GAO recently reviewed the program and found that it lacked an "effective monitoring system or clear and consistent monitoring guidance" and, as a result, grantees are "at risk of noncompliance with HHS policy or of not meeting performance requirements."[69] According to GAO, HHS "lacks mechanisms to identify and target grantees that are not in compliance with grant requirements or are not meeting performance goals, and it also lacks clear and consistent guidance for performing site monitoring visits."[70] Despite its goals, this program has not proven to be well managed and is simply not necessary. The benefits of marriage should continue to be emphasized in federal wellness efforts, but ACF's Healthy Marriage Promotion and Responsible Fatherhood Grants program should be eliminated.[71]

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[66] "TERMINATION: VOTING ACCESS FOR INDIVIDUALS WITH DISABILITIES GRANTS," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 83; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[67] "TERMINATION: VOTING ACCESS FOR INDIVIDUALS WITH DISABILITIES GRANTS," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 83; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[68] "Healthy Marriage Promotion and Responsible Fatherhood Grants," Catalog of Federal Domestic Assistance website, accessed July 6, 2011; https://www.cfda.gov/?s=program&mode=form&tab=step1&id=69b53231f092e7407bd5ad74ef0c58f3 .

[69] "HEALTHY MARRIAGE AND RESPONSIBLE FATHERHOOD INITIATIVE: Further Progress Is Needed in Developing a Risk-Based Monitoring Approach to Help HHS Improve Program Oversight (GAO-08-1002)," Government Accountability Office, September 2008, page 30; http://www.gao.gov/new.items/d081002.pdf .

[70] "HEALTHY MARRIAGE AND RESPONSIBLE FATHERHOOD INITIATIVE: Further Progress Is Needed in Developing a Risk-Based Monitoring Approach to Help HHS Improve Program Oversight (GAO-08-1002)," Government Accountability Office, September 2008, "Highlights" page; http://www.gao.gov/new.items/d081002.pdf .

[71] "HEALTHY MARRIAGE AND RESPONSIBLE FATHERHOOD INITIATIVE: Further Progress Is Needed in Developing a Risk-Based Monitoring Approach to Help HHS Improve Program Oversight (GAO-08-1002)," Government Accountability Office, September 2008, page 16; http://www.gao.gov/new.items/d081002.pdf .

The Low Income Home Energy Assistance Program (LIHEAP) provides financial assistance to help low-income families offset a portion of their home heating and cooling costs. The program's budget has increased dramatically in recent years as energy prices soared. The Obama Administration has proposed returning LIHEAP spending to $2.57 billion annually.[72] "Reflecting current forecasts for more moderate energy prices in winter 2011-2012," the Obama Administration says "this returns LIHEAP funding to historic levels received for 2008 prior to the energy price spikes."[73] The President's recommendation to return funding to the pre-energy budget should be adopted, saving taxpayers $2.5 billion.

The Centers for Disease Control and Prevention

Two-thirds of all deaths in the United States are the result of just five chronic diseases—heart disease, cancers, stroke, chronic obstructive pulmonary diseases, and diabetes.[74] These and other chronic diseases are not just costing lives, they are costing billions of dollars in medical bills every year. Chronic conditions are the "major factors driving virtually all Medicare spending growth for the past 15 years" according to a study published by the journal *Health Affairs*.[75] The federal government spends billions more treating infectious diseases, some of which have only been recently recognized like HIV/AIDS and hepatitis C. Yet, most of these diseases are largely preventable. As the saying goes, an ounce of prevention is worth a pound of cure. In terms of federal spending, an ounce of prevention could be worth a billion dollars in savings.

The Centers for Disease Control and Prevention (CDC) is the federal agency tasked with "protecting health and promoting quality of life through the prevention and control of disease, injury, and disability."[76] The dramatic increase in the number and cost of preventable conditions as well as the emergence of new public health threats such as bioterrorism underscore both the mission and challenges of the CDC.

The agency's essential and often challenging mission is too important to be neglected, even in times of financial austerity. This means ensuring optimal funding while holding the agency accountable for optimal results. CDC can boast success and be faulted with shortcomings. A recent example demonstrating both is the agency's response to the H1N1 outbreak: The agency reacted swiftly but discarded nearly one-third of the 229 million H1N1 vaccine purchased with taxpayer funds.[77]

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[72] "REDUCTION: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 126; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[73] "REDUCTION: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 126; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[74] "The Burden of Chronic Diseases as Causes of Death, United States," CDC website, accessed July 14, 2011; http://www.cdc.gov/nccdphp/burdenbook2004/Section01/tables.htm .

[75] Larry Wheeler, "Obesity, chronic disease drive Medicare costs up," USA Today, August 22, 2006; http://www.usatoday.com/news/washington/2006-08-22-medicare-obesity_x.htm .

[76] "About CDC," CDC website, accessed July 14, 2011; http://www.cdc.gov/about/ .

[77] Rob Stein, "Millions of H1N1 vaccine doses may have to be discarded," The Washington Post, April 1, 2010, Page A1; http://www.washingtonpost.com/wp-dyn/content/article/2010/03/31/AR2010033104201.html?hpid=moreheadlines .

Like other government agencies, CDC is not always the best steward of taxpayer funds, often times as a result of directives made by Congress. From spending billions of dollars on buildings to spending staff time investigating the media rather than disease outbreaks, CDC management has too often focused on the agency itself rather than its mission. The CDC spent about $1 billion on construction and repairs of its buildings and facilities over a recent five year period.[78] Yet the agency is spending another $400 million to build two multi-story buildings and expand parking lots.[79] After a series of critical press stories, the CDC "generated about 4,000 pages of documents assessing risks to the agency's reputation posed by *The Atlanta Journal-Constitution*'s reporting." The paper "was pursuing stories about morale problems and an exodus of key scientists from the Atlanta-based agency, CDC's chaotic response to Hurricane Katrina, lab animal welfare violations and costly taxpayer-funded construction projects."[80] This type of obsession with the agency's reputation is a waste of staff resources. The agency should be more focused on preventing disease which in turn would most likely help prevent negative news coverage.

A 2007 congressional oversight report, "CDC Off Center," provides a very detailed review of how the agency "spent hundreds of millions of tax dollars for failed prevention efforts, international junkets, and lavish facilities, but cannot demonstrate it is controlling disease."[81] The questionable spending outlined in the report includes hundreds of millions of dollars spent on lavish buildings, an unnecessary new office in Hawaii, $30,000 saunas for CDC employees, millions of dollars inappropriately awarded to former employees for questionable projects such as $1.7 million for a Hollywood liaison and a quarter of a million dollars for a morale booster, and the misuse of the CDC jet for political purposes.[82] The report also exposed millions of dollars being wasted on questionable and ineffective prevention programs, some with no objectives and others that violated federal guidelines.

Another congressional investigation found CDC could not account for more than $22 million worth of scientific equipment and thousands of other items including $500,000 of new computers.[83] While identifying some areas of waste and mismanagement at CDC, Congress has

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[78] CRS response to Senator Tom Coburn's request, September 2005. FY01-05 CDC construction and repair project expenditures equal $1,044,083,943. FY 2001: $72,609,521; FY 2002: $260,558,270; FY 2003: $83,697,080; FY 2004: $211,778,967; and FY 2005: $269,708,000.

[79] Craig Schneider, "CDC plans $400 million expansion; Plan is to build two 10-story research buildings," The Atlanta Journal-Constitution, August 13, 2009; http://www.ajc.com/news/atlanta/cdc-plans-400-million-115205.html .

[80] Alison Young, "SPOTLIGHT: WATCHING OUT FOR YOUR SAFETY AND POCKETBOOK; CDC sits on documents," The Atlanta Journal-Constitution, April 26, 2009; http://www.ajc.com/metro/content/metro/stories/2009/04/26/spotlight_cdc_documents.html .

[81] "CDC OFF CENTER; A review of how an agency tasked with fighting and preventing disease has spent hundreds of millions of tax dollars for failed prevention efforts, international junkets, and lavish facilities, but cannot demonstrate it is controlling disease," U.S. Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information, and International Security Minority (Senator Tom Coburn, Ranking Member), June 2007, page 8; http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f016bd58-8e45-45d4-951a-b6b4d1ef3e70 .

[82] "CDC OFF CENTER; A review of how an agency tasked with fighting and preventing disease has spent hundreds of millions of tax dollars for failed prevention efforts, international junkets, and lavish facilities, but cannot demonstrate it is controlling disease," U.S. Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information, and International Security Minority (Senator Tom Coburn, Ranking Member), June 2007, page 8; http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f016bd58-8e45-45d4-951a-b6b4d1ef3e70 .

[83] Alison Young, "Report: CDC can't find $22 million in equipment," The Atlanta Journal-Constitution, June 12, 2007; http://www.ajc.com/gwinnett/content/metro/dekalb/stories/2007/06/12/0612cdcequipment.html, Sharon Gaudin, "CDC Lost $22 Million Worth Of Computers And Equipment, Congressmen Charge," InformationWeek, July 13, 2007, http://www.informationweek.com/news/201001314

also contributed to duplication and misplaced priorities at CDC. Currently, CDC is funded through over one hundred appropriation budget lines. This is the result of years of funding decisions being made via earmarks for specific diseases or health conditions favored by Washington politicians, advocacy organizations, and celebrity spokespersons rather than by scientific experts or public health officials. This micromanagement of CDC has created waste, fragmentation, duplication, and mission creep. For example, CDC efforts addressing obesity, climate change, and fire safety as well as collection of data on violence duplicate efforts of other government agencies.

There are over 20 centers and offices comprising CDC. The silos within CDC created by Congress should be reconsidered.[84] The director of the agency should be given the authority to update and consolidate the organization to better reflect and respond to today's public health challenges and needs. A streamlined and updated CDC could be reorganized into five centers:

Office of the Director. Much like NIH, the CDC director should be provided greater flexibility, responsibility and accountability for the overall work of agency. The director should have the ability to respond to emerging threats or new understandings by having the authority to shift resources within and across CDC's centers. In exchange for turning over greater authority to the director, Congress will have to spend less time micromanaging CDC spending and more time conducting oversight of the results of the funding provided.

Health Promotion and Prevention. This center would focus on the leading causes of death and scientifically-proven ways of reducing disease burdens. It could incorporate all of the existing budget lines for health promotion and prevention for behavioral issues such as tobacco; nutrition; physical activity; obesity; visual screening; heart disease; and stroke and cancer . Combining prevention for all behavior-based health issues would encourage more coordinated efforts. A health awareness campaign for obesity, for example, would also address heart disease, diabetes, and other proper nutrition and exercise.

Disease Surveillance and Epidemiology (Health Statistics). Surveillance and epidemiology are core functions and roles for a public health agency. Unfortunately, CDC's disease surveillance is fractured. For example, the Center for Chronic Disease Prevention and Health Promotion funds the National Lupus Patient Registry and various cancer registries. All surveillance should be collected and processed by one center. The center should create uniform guidelines states could use to collect data.

Global Health. This center could monitor and respond to global outbreaks as well as support international efforts to combat HIV/AIDS, TB, and malaria.

In addition to these broader reforms, there are other areas where savings could be made within CDC's budget without undermining its mission. The "Justification of Estimates for

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[84] Center for Disease Control Website, "CDC Organization," http://www.cdc.gov/about/organization/cio.htm.

Appropriation Committees" for Fiscal Year 2012 proposed by CDC recommends a number of specific savings that should be adopted: [85]

Public Health Emergency Preparedness Grant Program ($71.6 million). The President's budget includes a $71.6 million reduction in the Public Health Emergency Preparedness (PHEP) Program. The PHEP program will provide nearly $9 billion in funding from 2001-2012. State and local governments play a key role in this area and there are many sources of funding for public health preparedness outside of CDC.

World Trade Center Health Monitoring Program ($70.7 million). The budget includes an elimination of discretionary funding for World Trade Center activities. The World Trade Center Health Program Created by the James Zadroga 9/11 Health and Compensation Act of 2010 will provide substantially more funding and was intended to replace these funds.

Academic Centers for Public Health Preparedness and Advanced Practice Centers ($35.3 million). The administration notes these programs have not demonstrated a large return on investment or significant impact improving public health.

Healthy Homes/Childhood Lead Poisoning Prevention/Asthma ($33 million). The President recommends consolidating the remaining funds for this program into a more comprehensive approach.

Healthy Communities ($22.6 million). There are other community-based programs funded by CDC.

Genomics ($11.6 million). Because of overlap with other federal agencies, the President recommends reducing CDC genomic activities by $11.6 million. CDC can use the reduced funding to focus on implementing applications of genomics to areas of public health importance.

Built Environment ($2.7 million). This program could be eliminated with some of its activities integrated into other CDC community-based programs.[86]

Additionally, CDC could raise some revenues to offset the costs of its museums which cost taxpayers millions of dollars to construct. Admission and parking at CDC's Global Health Odyssey Museum are free.[87] The museum features multi-media installations tracing "the origins and early history of CDC through its expansion into an agency of public health programs emphasizing prevention." [88] The museum also presents other exhibits using artwork intended to communicate wellness messages. Recent features include "*Off the Beaten Path*, which presents the work of 28 contemporary artists including Yoko Ono,[89] as well as a series of lounge chairs

[85] "Justification of Estimates for Appropriation Committees Fiscal Year 2012," Centers for Disease Control and Prevention; http://tinyurl.com/4tk3oog.
[86] "Justification of Estimates for Appropriation Committees Fiscal Year 2012," Centers for Disease Control and Prevention; http://tinyurl.com/4tk3oog.
[87] "Visit," CDC website, accessed July 14, 2011; http://www.cdc.gov/museum/visitor.htm .
[88] "Current Exhibits," CDC website, accessed July 14, 2011; http://www.cdc.gov/museum/exhibitions_changing.htm.
[89] "Current Exhibits," CDC website, accessed July 14, 2011; http://www.cdc.gov/museum/exhibitions_changing.htm.

"making a statement on global obesity and consumption" designed by an Atlanta sculptor.[90] Even if school groups were exempted, asking museum visitors to contribute a small fee of $5 could offset some of the museum costs, allowing more CDC funds to be directed towards disease control efforts.

Charging visitors a nominal fee would offset some of the costs of CDC's Global Health Odyssey Museum which features both health messages as well as the artwork of contemporary artists such as Yoko Ono as well as lounge chairs designed to make a "statement on global obesity and consumption."[91]

Health Resources and Services Administration

The Health Resources and Services Administration (HRSA) is comprised of six bureaus and 13 offices, administers over100 programs, and disperses federal funds to more than 3,000 grantees to provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. HRSA also oversees organ, bone marrow and cord blood donation, supports bioterrorism preparation programs, and maintains databases that protect against health care malpractice and health care waste, fraud and abuse. [92]

The federal government spends approximately $25 billion a year on HIV/AIDS, yet thousands of Americans living with the disease are on waiting lists for life saving treatment provided by government programs.[93] Millions of dollars intended to assist patients have been lost to fraud. Additionally, the federal government overpays pharmaceutical companies millions of dollars every month at the same time AIDS drug programs are enacting formulary restrictions due to funding shortages. Better management of these programs and targeting of resources could ensure more patients receive the care they need at a lower price to taxpayers.

[90] "Mark Wentzel's Eames Lounge Chairs Should Try Atkins," otto, August 18, 2009; http://www.otto-otto.com/2009/08/mark-wentzels-eames-lounge-chairs-should-try-atkins/ .
[91] "Mark Wentzel's Eames Lounge Chairs Should Try Atkins," otto, August 18, 2009; http://www.otto-otto.com/2009/08/mark-wentzels-eames-lounge-chairs-should-try-atkins/ .
[92] "About HRSA," Health Resources and Services Administration website, July 6, 2011; http://www.hrsa.gov/about/index.html .
[93] Judith Johnson, "RL30731 -- AIDS Funding for Federal Government Programs: FY1981-FY2009," Congressional Research Service, April 23, 2008, http://www.crs.gov/pages/Reports.aspx?PRODCODE=RL30731&Source=search.

While Medicare and Medicaid collectively spend nearly $10 billion a year to provide health care for Americans living with HIV/AIDS,[94] the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the federal government's single largest HIV/AIDS specific program. The CARE Act, with a budget of $2.2 billion, serves more than half a million HIV/AIDS patients, providing a range of services from doctors visits, medication and treatment to housing, transportation, and other forms of assistance.[95] [96] The availability of life saving drugs has transformed HIV from a terminal disease into a chronic disease for many. Yet, more than 8,500 Americans living with HIV/AIDS are on waiting lists for drugs provided by the CARE Act's AIDS Drug Assistance Program (ADAP).[97] Thousands of others with the disease are facing restrictions on drug formularies.

There are a number of reforms that could be implemented to ensure increased access to life saving treatments while reducing the cost of HIV/AIDS programs. First, at least 80 percent of funds provided by HRSA administered programs should be required to be spent on drugs and primary medical care and treatment (currently 75 percent is directed towards medical care). Other support services may be helpful but none have the same life or death impact as access to AIDS drugs.

Title I of the CARE Act mandated Eligible Metropolitan Areas (EMAs) establish a planning council to steer decision making by local governments in the disbursement of federal funds while such planning councils are optional for Transitional Grant Areas (TGAs). While localities should maintain the prerogative to use planning councils, local rather than federal funds should support the councils. This will ensure a greater amount of federal funds may be directed to care and treatment rather than consumed by meetings and administration.

The CARE Act contains a provision, known as the "hold harmless" provision, that ensures a single jurisdiction receives CARE Act funding based, in part, upon dead AIDS cases. "The San Francisco EMA continues to be the only urban area whose formula funding is based on both living and deceased AIDS cases," according to GAO. "All other EMAs received formula funding based on an estimate of the number of living AIDS cases."[98] It is outrageous to steer federal AIDS funds to the dead at the same time patients are dying on government waiting lists for AIDS drugs. This AIDS earmark for San Francisco should be eliminated with any funds that would have been distributed based upon dead patients redirected into ADAP.

HRSA overpays pharmaceutical companies millions of dollars every month. Both the HHS Office of Inspector General (OIG) and the GAO have issued reports calling attention to this costly problem. "Section 340B of the Public Health Service Act (PHS Act) established the 340B Drug Pricing Program (340B Program), which requires pharmaceutical manufacturers to charge at or below statutorily defined prices, known as the 340B ceiling prices, to qualified entities

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[94] Judith Johnson, "RL30731 -- AIDS Funding for Federal Government Programs: FY1981-FY2009," Congressional Research Service, April 23, 2008, http://www.crs.gov/pages/Reports.aspx?PRODCODE=RL30731&Source=search.
[95] "Funding," HRSA HIV/AIDS Programs website, accessed July 5, 2011; http://hab.hrsa.gov/data/reports/funding.html .
[96] "2008 State Profiles," HRSA HIV/AIDS Programs website, accessed July 5, 2011; http://hab.hrsa.gov/stateprofiles/.
[97] "ADAP Watch," National Alliance of State & Territorial AIDS Directors, June 24, 2011; http://www.nastad.org/Files/112517_ADAP%20Watch%20update%20-%207.8.11.pdf.
[98] "Ryan White Care Act: Impact of Legislative Funding Proposal on Urban Areas," Government Accountability Office letter to congressional requesters, October 5, 2007, page 16; http://www.gao.gov/new.items/d08137r.pdf .

(340B entities), including community health centers, public hospitals, and various Federal grantees," according to the OIG.[99] "Since 340B ceiling prices are based on confidential pricing data, they are not disclosed to 340B entities, leaving the entities unable to determine if the prices they pay are higher than the 340B ceiling prices.

The Health Resources and Services Administration (HRSA) is responsible for monitoring compliance with the 340B Program. Previous Office of Inspector General (OIG) studies have determined that HRSA does not systematically ensure that entities receive the prices to which they are entitled." In fact, "14 percent of total purchases made by 340B entities exceeded the 340B ceiling prices, resulting in total overpayments of $3.9 million" in a single month![100]

All of the 25 ADAPs that used the 340B direct purchase option to buy HIV/AIDS drugs paid prices higher than the 340B prices, according to GAO. Three paid prices that were higher than the 340B price for at least 8 of the 10 drugs reviewed.[101] "The 340B prices are not disclosed to ADAPs, but participating manufacturers agree to sell at the 340B prices," according to GAO. "HRSA is responsible for monitoring whether ADAPs obtain the best prices available for drugs, GAO notes, "however, HRSA does not routinely determine whether the prices ADAPs report are no higher than the 340B prices."[102] If HRSA is incapable of ensuring taxpayers are not being overcharged and drug companies continue to overbill, 340B entities should be provided the 340B prices to verify the cost themselves.

HRSA is overpaying pharmaceutical companies nearly $4 million a month for drugs provided by some federal health programs.

The Health Care Facilities and Construction program "provides congressional-directed funds to health facilities for construction-related activities and/or capital equipment purchases" and "funding is limited to earmarked entities."[103] A moratorium has been imposed on congressional-directed projects, also known as earmarks. As a result, the projects funded by this program will no longer be designated by Congress, making it obsolete. Federal funding for construction of health care facilities would still be available as 29 other programs administered by eight federal

[99] "REVIEW OF 340B PRICES (OEI-05-02-00073)," Department of Health and Human Services Office of Inspector General, July 2006; http://oig.hhs.gov/oei/reports/oei-05-02-00073.pdf .
[100] "REVIEW OF 340B PRICES (OEI-05-02-00073)," Department of Health and Human Services Office of Inspector General, July 2006; http://oig.hhs.gov/oei/reports/oei-05-02-00073.pdf .
[101] "RYAN WHITE CARE ACT: Improved Oversight Needed to Ensure AIDS Drug Assistance Programs Obtain Best Prices for Drugs (GAO-06-64)," Government Accountability Office, April 2006, page 32; http://www.gao.gov/new.items/d06646.pdf .
[102] "RYAN WHITE CARE ACT: Improved Oversight Needed to Ensure AIDS Drug Assistance Programs Obtain Best Prices for Drugs (GAO-06-64)," Government Accountability Office, April 2006; http://www.gao.gov/new.items/d06646.pdf .
[103] "The Health Care and Other Facilities (HCOF) Construction Program," HRSA website, accessed June 27, 2011; http://www.hrsa.gov/HCOFConstruction/index.html .

agencies support non-residential buildings and facilities construction, according to the Office of Management and Budget.[104] President Obama has proposed eliminating this program[105] and it is not funded in the current fiscal year. The program should be ended.

The Delta Health Initiative provides funding for health care projects in the Mississippi Delta, "including but not limited to access to care, economic development, health education, research and workforce development."[106] This program is essentially an earmark for a particular region. Congress has enacted a moratorium on earmarks, meaning this program should no longer be eligible for federal funding. The Delta Health Initiative funds projects only in Mississippi and the "projects are not subject to a competitive or merit-based process," according to the Office of Management and Budget, which also notes "there are other sources of funding in the Federal Government that can accomplish these goals." President Obama has proposed eliminating this program.[107] The program should be ended.

The Obama Administration has called for the termination of the *State Health Access Program* because the goals of the program will be met by other federal programs.[108] The bill creating the State Health Access Program was actually signed by President Obama in 2009.[109] This program, with an annual budget of $74 million, provides grants to States to expand access to health care coverage for uninsured populations.[110] HHS is already distributing $5 billion through other initiatives to states to support high risk pool programs.[111]

The Rural Access to Emergency Devices program was created in 2002 to provide federal funding to rural communities to purchase automated external defibrillators (AEDs). According to the Office of Management and Budget, "much of the demand for these medical devices has been met through prior grants and future demand can be met through other rural health activities in HRSA. Moreover, costs of defibrillators have become more affordable in the last ten years from over $10,000 to under $2,000 today." President Obama has called for the elimination of the Rural Access to Emergency Devices program and Congress should end it.[112]

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[104] "HEALTH RESOURCES AND SERVICES ADMINISTRATION (3 TERMINATIONS)," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 36; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[105] "HEALTH RESOURCES AND SERVICES ADMINISTRATION (3 TERMINATIONS)," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 36; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[106] TERMINATION: STATE HEALTH ACCESS GRANTS," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf

[107] "HEALTH RESOURCES AND SERVICES ADMINISTRATION (3 TERMINATIONS)," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 36; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[108] "TERMINATION: STATE HEALTH ACCESS GRANTS," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 72; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[109] "State Health Access Program," HRSA website, accessed July 1, 2011; http://www.hrsa.gov/statehealthaccess/ .

[110] "Justification of Estimates for Appropriation Committees Fiscal Year 2012," Health Resources and Services Commission, http://www.hrsa.gov/about/budget/summarybudgetjust2012.pdf.

[111] "Fact Sheet – Temporary High Risk Pool Program," HHS website, accessed July 1, 2011; http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html .

[112] "TERMINATION: SMALL CATEGORICAL GRANTS (3 TERMINATIONS)," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 67; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

The Adolescent & Young Adult Health Program collects and disseminates information relevant to the health, safety, development, and social and economic well-being of young people between the ages of 10 and 24. This includes analyzing the effects of public policies and regulations, assisting state develop strategies for improving measurable health, safety and developmental outcomes, and supporting "a national membership association to assist its members and affiliates in developing improved approaches for delivering adolescent and young adult public health programs at the state level."[113] While these goals are noble, these activities are duplicative of a number of other HHS agencies, including the Centers for Disease Control and Prevention (CDC), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and other HRSA programs such as the Leadership Education in Adolescent Health (LEAH) Training Program. This program should be eliminated with any essential ongoing projects and initiatives consolidated within the most appropriate program at CDC or NICHD.

The Safety Promotion and Injury & Violence Prevention program "promotes infant, child and adolescent safety through training and technical assistance to States and other organizations. It assures that the appropriate evidence-based resources are available to end users for application in prevention efforts throughout their diverse environments."[114] This largely duplicates the role and mission of CDC's National Center for Injury Prevention and Control which lead's federal injury and violence prevention efforts.[115] CDC's Striving to Reduce Youth Violence Everywhere is a national initiative, "which takes a public health approach to preventing youth violence before it starts," providing the latest information and tools, effective strategies based upon the best available evidence, training and technical assistance, and connections to other communities. [116] HRSA's Safety Promotion and Injury & Violence Prevention program also duplicates other HRSA programs such as the Healthy Child Care America program which disseminates information related to injury prevention.[117] The National Institutes of Health also provides resources on injuries[118] and violence.[119]

Promoting safety and prevention violence are important missions, but duplicative efforts only waste limited resources on overlap and redundancy without improving outcomes. The Safety Promotion and Injury & Violence Prevention program at HRSA should be eliminated and any ongoing programs that have proven to be effective reassigned to the appropriate other program that addresses these issues.

Implement Health Care Terminations from President Obama's FY2012 Budget

[113] "Adolescent & Young Adult Health Program," HRSA Maternal and Child Health website, accessed July 5, 2011; http://mchb.hrsa.gov/programs/adolescents/index.html .
[114] "Injury & Violence Prevention and Safety Promotion," HRSA Maternal and Child Health website, accessed July 6, 2011; http://mchb.hrsa.gov/programs/injuryprevention/index.html .
[115] *"Injury Prevention & Control," CDC website, accessed July 6, 2011; http://www.cdc.gov/injury/overview/* .
[116] Striving to Reduce Youth Violence Everywhere website, accessed July 6, 2011; http://www.safeyouth.gov/Pages/Home.aspx .
[117] "Programs A-Z," HRSA Maternal and Child Health website, accessed July 6, 2011; http://mchb.hrsa.gov/AZ/azdescriptions.html .
[118] "Injuries and Wounds," NIH website, accessed July 6, 2011; http://health.nih.gov/category/InjuriesandWounds .
[119] "Children and Violence," NIH website, accessed July 6, 2011; http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/children-and-violence.shtml .

President Obama has proposed eliminating a number of other programs in HRSA and other agencies at the U.S. Department of Health and Human Services.[120] These recommendations should be adopted.

The Department of Health and Human Services has an *Adolescent Family Life Program* that may be unnecessary based on other available resources. Efforts to encourage teen pregnancy prevention and providing quality prenatal care to teen mothers and families are already addressed through other funding federal, state, and non-governmental funding streams. This duplicative effort should be ended.[121] Eliminating this program saves taxpayers $17 million annually.

The Department of Health and Human Services should not be operating *Agriculture, Forestry, and Fishing Program*; such a program duplicates other federal programs. Furthermore, according to the President's FY2012 budget:

> "the National Academies stated that the Agriculture, Forestry, and Fishing (AFF) Program lacked a single cohesive vision to drive the research agenda and that the lack of consistent leadership, long-term strategic planning, and periodic review of that course led to a piecemeal approach to the research that appeared disjointed more often than not. The National Academies also stated that the AFF Program has not always focused on the most appropriate cases and that workers have not accepted the majority of research contributions."

Additionally, the study found that "there was little evidence that the research activities, outputs, and intermediate outcomes contributed to the stated end outcomes of reducing workplace injury and illness."[122] Eliminating this program saves taxpayers $23 million annually.

Taxpayers subsidize a *Children's Hospital Graduate Medical Education Payment Program*, despite spending billions on graduate medical education in other programs. As the President's FY2012 budget noted, Congress appropriated $318 million for the Children's Hospital Graduate Medical Education (CHGME) payment program in 2010, which provides a taxpayer-funded subsidy to certain children's hospitals. The proposal eliminates this subsidy, but taxpayers will continue to fund medical education in through other sources.[123] Eliminating this program saves taxpayers $318 million over a decade.

The President's FY2012 budget explains that *Education Research Centers Program (ERCs)* were "created in the mid-1970s to provide seed money for academic institutions to develop or expand occupational health and safety training programs for specialists currently practicing in

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[120] "TERMINATION: CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 16; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[121] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 9. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf

[122] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 10. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf

[123] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 16. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf

the field."[124] The world has changed dramatically in the last decades, and the program has outlived its original mission. The President's budget says that National Institute for Occupational Safety and Health "has met the goal as originally intended for this program," noting that in 2000, there were an estimated 175 occupational and safety health programs across the United States. Terminating this program saves taxpayers $25 million each year.

In 2010, the Congress appropriated taxpayer money for unrequested local health projects, including $10 million to the *Denali Commission* that funds construction of health facilities in Alaska.[125] The President's FY2012 budget pointed out that a GAO report "identified 29 other programs across eight Federal agencies that support non-residential buildings and facilities construction,"[126] and concluded that "meritorious projects should be able to receive funding under a competitive process."

According to the President's FY2012 budget, the *Preventive Health and Health Services Block Grant* (PHHSBG) "currently funds 265 separate activities" yet "is less than one percent of State budgets."[127] The budget explains that "when PHHSBG was first authorized in 1981, there were minimal resources within CDC's budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity and many States did not receive funding from CDC to support prevention of Chronic disease." However, since that time, CDC spending has ballooned and PHHSBG funds are not a significant percentage of State budgets compared to other sources of federal health care funding.[128]

The President's 2012 Budget removes funding from health workforce activities including *Allied Health and Other Disciplines* and *Patient Navigators.* Allied Health spending has outlived its usefulness since its creation, since research protocols have been developed from the funding focused on the treatment of lower back pain. The President's budget notes there is "no performance data associated" with the Patient Navigator program.[129]

Both the *Racial and Ethnic Approaches to Community Health (REACH) program* and the *Healthy Communities program* support small-scale community-based approaches to improve health in communities, health care settings, schools, and work sites. Community-based approaches should be developed and funded at the community—not federal—level. And, as the President's 2012 Budget notes, though "some of these activities may have improved health outcomes in some settings, there have been no overall health outcome measures for these

[124] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 23. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[125] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 36. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[126] Government Accountability Office, Multiple Federal Programs Fund Similar Economic Development Activities, GAO/RCED/GGD-00-220, September 2000.
[127] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 55. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[128] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 55. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[129] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 67. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf

activities and they have not been scalable at the national level."[130] These programs should be eliminated.

The President's FY2012 Budget calls for a reduction of *the Developmental Disabilities Projects of National Significance* "so that resources can be preserved in priority programs with a stronger track record."[131] The Budget specifically notes that "Many projects supported by this program in recent years were not measured or evaluated, reached only a few families, and were not scalable or sustainable." Eliminating this program saves taxpayers more than $140 million over a decade.

National Institutes for Health

The National Institutes of Health (NIH) is regarded as the nation's premier medical research agency. NIH is composed of 27 Institutes and Centers which focus on specific research agendas or particular diseases or body systems. NIH has an annual budget of $31 billion budget.[132] Spending by NIH nearly tripled from 1997 to 2010, according to the Congressional Budget Office (CBO).[133] In addition, the stimulus program provided an additional $10.4 billion to NIH.[134] Under this plan, NIH will serve an even greater role as it will assume the federal research projects being conducted by other federal agencies that duplicate NIH's mission.

A number of other agencies across the government, including the Department of Defense, are replicating research conducted by NIH. Because of its leading role in medical research, these efforts should be consolidated within NIH to ensure improved coordination while reducing unnecessary spending for duplicative overhead and administration costs. The result will be greater resources for actual research that is better coordinated. Unlike other federal

Spending by the National Institutes of Health, the nation's premier medical research agency, nearly tripled from 1997 to 2010. The agency's role and budget will continue to increase under this proposal.

[130] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 68. http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[131] Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 105 http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf
[132] Judith A. Johnson and Pamela W. Smith, "The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues," Congressional Research Service, June 27, 2011.
[133] Judith A. Johnson and Pamela W. Smith, "The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues," Congressional Research Service, June 27, 2011.
[134] Judith A. Johnson and Pamela W. Smith, "The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues," Congressional Research Service, June 27, 2011.

agencies that will experience funding reductions, NIH would continue to receive an annual funding increase of one percent under this proposal.

Because scientists are more qualified to determine what research holds the most promise and which grant applications have the most merit, NIH largely determines its own scientific funding priorities and should continue to do so. It is the responsibility of Congress, however, to conduct oversight on NIH spending to ensure the significant resources U.S. taxpayers are providing to the agency are being spent wisely.

The Congressional Budget Office (CBO) argues a more modest increase in annual NIH funding could have positive impacts, including "increased efficiencies" with "more careful focus on priorities that will provide the greatest benefits" and "some costs could probably be reduced or eliminated without harming high-priority research."[135] Without question, there are hundreds of millions of dollars being spent by NIH and other federal research agencies that could be more wisely spent to get better returns for taxpayers at a lower price.

NIH has awarded an $11,315,226 contract earlier this year for conference and logistic support services.[136] While scientific gatherings do have value for the exchange of ideas and data, this is an excessive amount for a single agency. This amount should be reduced to $8.5 million and NIH should make greater efforts to utilize teleconferencing and other technologies that allow for information sharing.

[135] "Reduce or Constrain Funding for the National Institutes of Health," REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS, Congressional Budget Office, March 2011; page 121; http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf .

[136] "R--Scientific Conference, Scientific Logistic Support & Other Support Services for the NIDDK," Solicitation Number NIHLM2010036, Federal Business Opportunities website, date posted February 25, 2011; https://www.fbo.gov/?s=opportunity&mode=form&id=0b29b4ef548b9f62c468242adad5b246&tab=core&_cview=1 .

NIH is paying more than $11.3 million for meetings and conferences this year.

The National Center for Complementary and Alternative Medicine (NCCAM) was established by Congress in 1999 to support research of complementary and alternative medicine (CAM), which is "interventions, practices, products, or disciplines that are not generally considered part of conventional medicine"[137] Americans spend $34 billion a year on a range of alternative therapies, such as herbs and yoga classes, according to research conducted by NIH with CDC.[138]

The National Center for Complementary and Alternative Medicine at NIH is studying "whether brain waves emitted from a special 'master' can help break cocaine addiction," along with a number of other questionable alternative practices considered "nonsense" by some scientific experts.

However, this center was not created at the request of NIH or the scientific community, but rather by a number of influential politicians who used alternative medicine. "That is opposite how other National Institutes of Health agencies work, where scientific evidence or at least plausibility is required to justify studies, and treatments go into wide use after there is evidence they work — not before," pointed out an Associated Press investigative story which examined the impact of NCCAM.[139] After spending $2.5 billion over ten years studying herbal and other alternative health remedies to determine which ones work, "the disappointing answer seems to be that almost none of them do," the AP analysis found. "All proved no better than dummy pills in big studies funded by the National Center for Complementary and Alternative Medicine. The lone exception: ginger capsules may help chemotherapy nausea.

As for therapies, acupuncture has been shown to help certain conditions, and yoga, massage, meditation and other relaxation methods may relieve symptoms like pain, anxiety and fatigue. However, the government also is funding studies of purported energy fields, distance healing and other approaches that have little if any biological plausibility or scientific evidence.

Taxpayers are bankrolling studies of whether pressing various spots on your head can help with weight loss, whether brain waves emitted from a special 'master' can help break cocaine addiction, and whether wearing magnets can help the painful wrist problem, carpal tunnel syndrome."[140] The NCCAM Director, Dr. Josephine Briggs, "conceded there were no big wins from its first decade, other than a study that found acupuncture helped knee arthritis" but "that

[137] "Mission," National Center for Complementary and Alternative Medicine website, accessed June 28, 2011; http://www.nih.gov/about/almanac/organization/NCCAM.htm .
[138] Liz Szabo, "Americans spend $34 billion a year on alternative medicine," USA Today, July 30, 2009; http://www.usatoday.com/news/health/2009-07-30-alternative-medicine_N.htm .
[139] Marilynn Marchione, "AP IMPACT: $2.5B spent, no alternative med cures," Associated Press, June 10, 2009; http://seattletimes.nwsource.com/html/health/2009322791_apusmedunprovenremediesresearch.html?syndication=rss .
[140] Marilynn Marchione, "AP IMPACT: $2.5B spent, no alternative med cures," Associated Press, June 10, 2009; http://seattletimes.nwsource.com/html/health/2009322791_apusmedunprovenremediesresearch.html?syndication=rss .

finding was called into question when a later, larger study found that sham treatment worked just as well."[141] This institute should be eliminated with any promising studies reassigned to another appropriate NIH center.

The National Cancer Institute (NCI), established in 1937, conducts and supports research to identify, prevent, control, and better treat cancer. NCI's budget this year is more than $5 billion.[142] While more than $100 billion has been spent by NCI over the last four decades, as *The New York Times* reported, "the fight against cancer is going slower than most had hoped, with only small changes in the death rate in the almost 40 years since it began."[143] *The New York Times* notes "one major impediment, scientists agree, is the grant system itself. It has become a sort of jobs program, a way to keep research laboratories going year after year with the understanding that the focus will be on small projects unlikely to take significant steps toward curing cancer."[144]

For example, NCI awarded a $100,000 grant for a study to determine if those most tempted by tasty foods have the most difficulty staying on a diet. The principal investigator "said he realized it would hardly cure cancer." "Another study will assess a Web-based program that encourages families to choose more healthful foods. Many other grants involve biological research unlikely to break new ground." [145] Dr. Raynard Kington, who served as acting director of the National Institutes of Health, acknowledges "the system probably provides disincentives to funding really transformative research." [146]

Dr. Otis W. Brawley, who served in numerous roles at NCI, believes cancer research is too cautious and "the problem of getting money for imaginative but chancy proposals had worsened in recent year," in part, because "there are more scientists seeking grants — they surged into the field in the 1990s when the National Institutes of Health budget doubled." [147]

NCI will be entrusted with taking over cancer research currently being conducted by the Department of Defense. To ensure greater progress over the next decade, NCI should place a greater emphasis on transformative research that may be riskier, but also holds greater potential of unlocking greater mysteries rather than steering funds towards lower priority studies such as the temptation of tasty foods.

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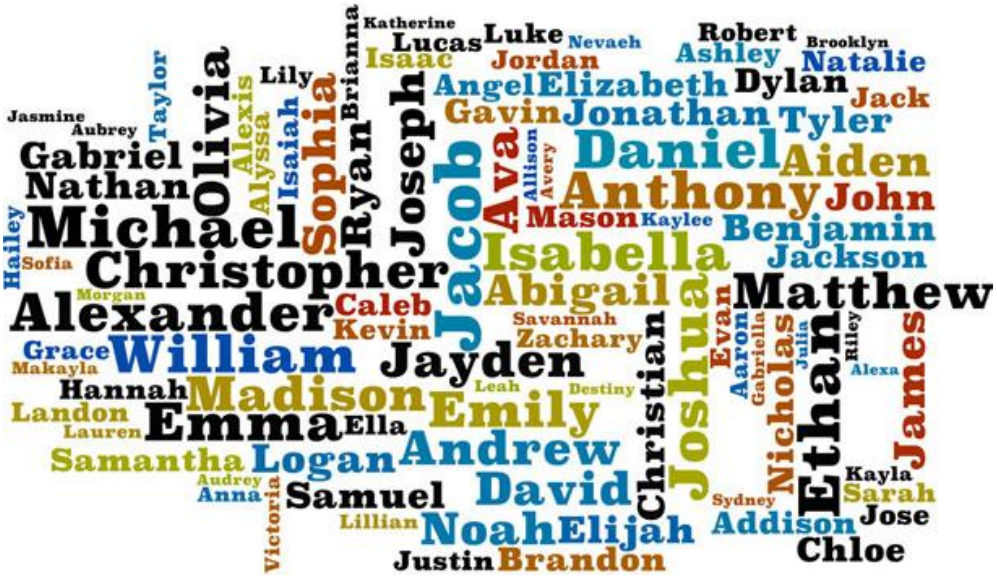
[141] Marilynn Marchione, "AP IMPACT: $2.5B spent, no alternative med cures," Associated Press, June 10, 2009; http://seattletimes.nwsource.com/html/health/2009322791_apusmedunprovenremediesresearch.html?syndication=rss .
[142] Judith A. Johnson and Pamela W. Smith, "The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues," Congressional Research Service, June 27, 2011.
[143] Gina Kolata, "Grant System Leads Cancer Researchers to Play It Safe," New York Times, June 28, 2009; http://www.nytimes.com/2009/06/28/health/research/28cancer.html?pagewanted=print
[144] Gina Kolata, "Grant System Leads Cancer Researchers to Play It Safe," New York Times, June 28, 2009; http://www.nytimes.com/2009/06/28/health/research/28cancer.html?_r=3&ref=instapundit .
[145] Gina Kolata, "Grant System Leads Cancer Researchers to Play It Safe," New York Times, June 28, 2009; http://www.nytimes.com/2009/06/28/health/research/28cancer.html?_r=3&ref=instapundit .
[146] Gina Kolata, "Grant System Leads Cancer Researchers to Play It Safe," New York Times, June 28, 2009; http://www.nytimes.com/2009/06/28/health/research/28cancer.html?_r=3&ref=instapundit .
[147] Gina Kolata, "Grant System Leads Cancer Researchers to Play It Safe," New York Times, June 28, 2009; http://www.nytimes.com/2009/06/28/health/research/28cancer.html?_r=3&ref=instapundit .

The National Cancer Institute will assume a greater role in directing federal research dollars, and therefore must place a greater emphasis on transformative research rather than continuing to explore less important questions, such as if those most tempted by tasty foods have difficulty sticking to a diet.

To be fair, NCI is not the only NIH component that has squandered money on studies and projects with no obvious health benefits. The National Institute of Alcohol Abuse and Alcoholism is spending $2.6 million to train Chinese prostitutes to drink responsibly on the job,[148] the National Institute of Child Health and Human Development is spending almost a half-a-million dollars to study why men don't like to wear condoms,[149] the National Institute of Mental Health financing research into parent's preference for trendy baby names,[150] the National Heart, Lung, and Blood Institute sponsors an annual fashion show,[151] and the National Institute of Allergy and Infectious Diseases has spent millions of dollars over the past decade on "HIV Vaccine Awareness Day,"[152] even though there is no HIV vaccine that exists to be aware of and most researchers do not expect one to be developed anytime soon. These and other lower priority projects should be canceled. The result would be savings for taxpayers and more funding for scientists to invest in transformative scientific research.

[148] Edwin Mora, "U.S. Will Pay $2.6 Million to Train Chinese Prostitutes to Drink Responsibly on the Job," CNSNews.com, May 12, 2009; http://www.cnsnews.com/node/47976 .
[149] "NIH Funds $423,500 Study of Why Men Don't Like to Use Condoms," FOX News, June 19, 2009; http://www.foxnews.com/politics/2009/06/19/nih-funds-study-men-dont-like-use-condoms/ .
[150] Sharon Jayson, "Study: U.S. parents respond quickly to trendy baby names," USA Today, October 13, 2009; http://www.usatoday.com/news/health/2009-10-13-baby-names_N.htm .
[151] "The Heart Truth® drives awareness throughout American Heart Month," The National Heart, Lung, and Blood Institute website, accessed June 30, 2011; http://www.nhlbi.nih.gov/educational/hearttruth/ .
[152] "National HIV Vaccine Awareness Day," National Institute of Allergy and Infectious Diseases website, May 18, 2011; http://www.niaid.nih.gov/news/newsreleases/2011/Pages/HVAD2011.aspx .



NIH research identified these as the 50 most popular baby names in 2008.[153] While the findings may be interesting to some, NIH could ask less from taxpayers while providing more for scientists by investing in more transformative scientific research.

Like any other long established bureaucracy, NIH could realize additional savings with simple restructuring that focused on consolidating duplicative and overlapping missions. Michael Crow, a former professor of science policy at Columbia University notes "despite its remarkable contributions to fundamental research, the NIH remains a fragmented bureaucracy."[154]

Streamlining and updating the structure of NIH to better reflect today's health care needs and scientific understandings would ensure better targeting of research dollars. There is no shortage of duplication that should be addressed. Twenty-seven NIH components, for example, are involved with obesity research[155] as are other HHS agencies, such as CDC, and agencies within other Departments, such as the National Institute of Food and Agriculture at the U.S. Department of Agriculture. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) focuses on alcoholism and related problems while the National Institute on Drug Abuse (NIDA) addresses drug abuse and addiction. The two institutes should be consolidated into a single National Institute on Addiction and Substance Abuse to better address these very similar and often overlapping fields. NIH has an Office of AIDS Research (OAR) but NIH calls the National Institute of Allergy and Infectious Diseases (NIAID) "the leading U.S. government institute for HIV/AIDS research."[156] Even the name of the Office of AIDS Research is outdated. In 1988, the same year OAR was established, the first Presidential Commission on the Human Immunodeficiency Virus Epidemic issued a report concluding "the term 'AIDS' is obsolete.

[153] Sharon Jayson, "Study: U.S. parents respond quickly to trendy baby names," USA Today, October 13, 2009; http://www.usatoday.com/news/health/2009-10-13-baby-names_N.htm .
[154] Michael M. Crow, "Growing a better NIH; A radical way to fix the nation's medical-research establishment," The Boston Globe, June 19, 2011; http://articles.boston.com/2011-06-19/bostonglobe/29677537_1_nih-medical-research-health-care/4 .
[155] Michael M. Crow, "Growing a better NIH; A radical way to fix the nation's medical-research establishment," The Boston Globe, June 19, 2011; http://articles.boston.com/2011-06-19/bostonglobe/29677537_1_nih-medical-research-health-care/5 .
[156] "NIAID's HIV/AIDS Research Program," NIAID website, accessed June 29, 2011; http://www.niaid.nih.gov/topics/hivaids/Pages/Default.aspx .

'HIV infection' more correctly defines the problem."[157] The essential activities conducted by OAR should be consolidated into NIAID, which should direct and coordinate the federal government's HIV/AIDS research.

There are three separate HIV/AIDS advisory panels at NIH. The AIDS Research Advisory Committee (ARAC), the AIDS Vaccine Research Subcommittee (AVRS), and the Strategic Working Group (SWG).[158] While each may provide input and guidance when setting scientific priorities, the three groups should be consolidated into a single HIV/AIDS Research Advisory Committee.

The Office of AIDS Research focuses on "scientific, budgetary, legislative, and policy elements"[159] of HIV research, but the National Institute of Allergy and Infectious Diseases is regarded as "the leading U.S. government institute for HIV/AIDS research."[160] These programs should be consolidated to improve coordination and eliminate wasteful redundancy for which taxpayers are paying.

Office of the Assistant Secretary for Health

The Office of the Assistant Secretary for Health (ASH) oversees 14 core public health offices and 10 regional health offices across the nation, and 10 Presidential and Secretarial advisory committees. The offices overseen by the ASH include the Office of the Surgeon General and the U.S. Public Health Service Corps.[161]

Because the Surgeon General has often been the most visible and respected public health official within the federal government, this position should assume the role of the ASH. This would effectively consolidate both roles, thereby eliminating the current ASH position.

Two separate entities addressing HIV/AIDS policy fall under the supervision of the ASH. Because the Office of HIV/AIDS Policy (OHAP) is responsible for coordinating HIV/AIDS policies, programs, and activities, the Presidential Advisory Council on HIV/AIDS (PACHA)

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[157] "Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic," The Presidential Commission on the Human Immunodeficiency Virus Epidemic, Executive summary page XVII, June 24, 1998.
[158] "HIV/AIDS Advisory Committees," NIAID website, accessed July 6, 2011; http://www.niaid.nih.gov/topics/hivaids/research/pages/advisorygroups.aspx .
[159] "Welcome to the NIH Office of AIDS Research," Office of AIDS Research website, accessed June 29, 2011; http://www.oar.nih.gov/ .
[160] "NIAID's HIV/AIDS Research Program," NIAID website, accessed June 29, 2011; http://www.niaid.nih.gov/topics/hivaids/Pages/Default.aspx .
[161] Office of the Assistant Secretary for Health website, accessed July 6, 2011; http://www.hhs.gov/ash/ .

should be eliminated. PACHA has no authority to direct any program. It does provide a forum to discuss and debate issues related to HIV/AIDS but its visibility and impact have lessened considerably in recent years. Perhaps no other advocacy groups are more effective or vocal than HIV/AIDS activists, further making PACHA obsolete and unnecessary.

The Office of Disease Prevention and Health Promotion (ODPHP) within the office of the ASH develops and coordinates national disease prevention and health promotion activities. This mission duplicates the role of the more premier federal prevention and health promotion agency, the Centers for Disease Control and Prevention, as well as other agencies and programs. It should be eliminated with any effective ongoing projects reassigned to the CDC for completion.

Family Planning, Teen Pregnancy Prevention, Reproductive Health Programs/Agencies

Multiple offices and agencies within the federal government administer a variety of programs providing family planning and pregnancy prevention services and various forms of contraception and sex education.

These programs include Medicaid Family Planning (Title XIX of the Social Security Act), Title X Family Planning, the Maternal and Child Health block grant (Title V of the Social Security Act), the Temporary Assistance for Needy Families (TANF) block grant (Title IV-A of the Social Security Act), the Title XX Social Services block grant, and several other HHS programs. "Over the past two decades, Medicaid has played a central and growing role in financing and providing access to family planning services for low-income women," according to the Kaiser Family Foundation, in part because "federal law requires state Medicaid programs to cover family planning services and supplies for beneficiaries."[162]

The Title V Abstinence Education Block Grant provides $50 million annually to states to support abstinence education. Two new programs were recently created to address the same issues, the Teen Pregnancy Prevention program (TPP) and the Personal Responsibility Education Program.[163]

The Office of Adolescent Health (OAH) coordinates adolescent health programs and initiatives administered by HHS, including teen pregnancy programs. The Office of Population Affairs (OPA) at HHS addresses population, reproductive health and family planning issues. The CDC has a number of offices addressing reproductive health. These include the CDC Division of Reproductive Health[164] and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention which finances sexually transmitted disease (STD) prevention programs in

[162] "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings," Kaiser Family Foundation website, accessed July 6, 2011; http://www.kff.org/womenshealth/8015.cfm .
[163] Carmen Solomon-Fears, "Teenage Pregnancy Prevention: Statistics and Programs," Congressional Research Service, June 21, 2011, http://www.crs.gov/pages/Reports.aspx?PRODCODE=RS20301&Source=search.
[164] "About Division of Reproductive Health," CDC's Division of Reproductive Health website, accessed July 6, 2011; http://www.cdc.gov/reproductivehealth/DRH/index.htm .

collaboration with government and nongovernmental partners at community, state, national, and international levels.[165] NIH and USAID also conduct reproductive health related research.

While some of these programs may compliment others, others simply overlap and duplicate, many have failed to demonstrate effectiveness, and some contradict others. The patchwork of overlapping programs is not an effective approach. The CDC is the appropriate federal agency to promote STD prevention and abstinence should remain the first line of defense to prevent teen pregnancy and STDs. States should continue to have the flexibility to manage Medicaid and block grants, but the other reproductive health programs should be ended and consolidated within CDC's existing programs.

The Adolescent Family Life program (AFL) is one of the many HHS programs focused on teen pregnancy prevention and related services. President Obama is proposing eliminating AFL because it is duplicative of a number of larger programs.[166] AFL should be ended, along with both the Teen Pregnancy Prevention program and the Personal Responsibility Education program, with any ongoing projects that have demonstrated effectiveness consolidated with the appropriate federal program that shares a similar mission.

The Title X Family Planning program has been controversial for a numbers of reasons, in part because it funds entities that fund abortion such as the Planned Parenthood Federation of America. "The prohibition on abortion does not apply to all the activities of a Title X grantee, but only to activities that are part of the Title X project. The grantee's abortion activities must be 'separate and distinct' from the Title X project activities," according to the Congressional Research Service.[167] Because "most states offer broad coverage for prescription contraceptives in their Medicaid programs"[168] and multiple other federal programs exist providing identical contraceptive and reproductive health services, Title X should be ended.

Again, abstinence should remain the first line of defense to prevent teen pregnancy and STDs, but the Title V Abstinence Education Block Grant should also be eliminated and CDC should ensure a proportion of sex education and STD and pregnancy prevention funds support messages and initiatives promoting the health benefits of delaying sexual activity, marriage, and faithfulness and monogamy.

PROGRAMS/OFFICES ELIMINATED:

- The Adolescent Family Life program ($17 million a year)[169]

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[165] CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention website, accessed July 6, 2011; http://www.cdc.gov/nchhstp/About.htm .

[166] "TERMINATION: ADOLESCENT FAMILY LIFE PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 9; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

[167] Angela Napili, "Title X (Public Health Service Act) Family Planning Program," Congressional Research Service, May 4, 2011.

[168] "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings," The Kaiser Family Foundation and the George Washington University Medical Center School of Public Health and Health Services, November 2009, page 3; http://www.kff.org/womenshealth/upload/8015.pdf .

[169] "TERMINATION: ADOLESCENT FAMILY LIFE PROGRAM," Fiscal Year 2012 Terminations, Reductions, and Savings; Budget of the U.S. Government, Office of Management and Budget, page 9; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/trs.pdf .

- The Children's Hospital Graduate Medical Education ($318 million a year)
- The Community Economic Development program ($36 million a year)
- The Community Service Block Grant program ($700 million a year)
- The Delta Health Initiative program ($35 million a year)
- The Health Care Facilities and Construction program ($337 million a year)
- Health workforce activities ($2 million a year)
- Healthy Marriage Promotion and Responsible Fatherhood Grants ($150 million a year)
- The Job Opportunities for Low-Income Individuals program ($3 million a year)
- The National Center for Complementary and Alternative Medicine ($129 million a year)[170]
- The Patient Navigator program ($5 million a year)
- The Personal Responsibility Education program ($75 million a year)[171]
- Rural Access to Emergency Devices program ($3 million a year)
- Rural Community Facilities program ($10 million a year)
- State Health Access Program ($74 million a year)
- Teen Pregnancy Prevention program ($110 million a year)[172]
- Title V Abstinence Education Block Grant ($50 million a year)[173]
- Title X Family Planning program ($317 million a year)[174]
- The Voting Access for Individuals with Disabilities grant program ($17 million a year)

ADDITIONAL SAVINGS/PROGRAM REDUCTIONS:

- President Obama's FY2012 reduction in administrative spending ($200 million a year)
- Capping departmental management spending on travel ($2 million a year)
- Capping equipment expenditures by departmental management ($3.1 million a year)
- Capping printing and reproduction costs within departmental management ($3.2 million a year)
- Capping departmental management supplies and materials costs ($5.5 million a year)
- Capping office of the Assistant Secretary for Legislation budget ($1.4 million)
- Ensuring 340B entities do not overpay 340B ceiling prices for pharmaceuticals ($3.9 million a month)[175]
- Reduce Assistant Secretary for Public Affairs budget ($15.9 million a year)
- Returning Low Income Home Energy Assistance Program funding to the levels prior to the energy price spikes ($2.53 billion a year)
- NIH funding increase of one percent ($13 billion over ten years)[176]

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[170] Appropriations History, National Center for Complementary and Alternative Medicine website, accessed July 2011. http://nccam.nih.gov/about/budget/appropriations.htm

[171] Solomon-Fears, Carmen. "Teenage Pregnancy Prevention: Statistics and Programs," Congressional Research Service, June 21, 2011 (RS20301).

[172] Solomon-Fears, Carmen. "Teenage Pregnancy Prevention: Statistics and Programs," Congressional Research Service, June 21, 2011 (RS20301).

[173] Solomon-Fears, Carmen. "Teenage Pregnancy Prevention: Statistics and Programs," Congressional Research Service, June 21, 2011 (RS20301).

[174] Family Planning, Office of Population Affairs, U.S. Department of Health and Human Services. http://www.hhs.gov/opa/familyplanning/index.html

[175] "Review of 340B Programs," Office of the Inspector General, U.S. Department of Health and Human Services, July 2006, OEI-05-02-00073.

- NIH conferences and support services ($2.8 million a year)[177]
- Consolidate the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse (undetermined)
- Consolidate the Office of AIDS Research into the National Institute of Allergy and Infectious Diseases (undetermined)

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is charged with increasing access to substance abuse and mental health services. SAMHSA was first established in 1992 and reauthorized just once in 2000. SAMSHA's 2011 budget stands at $3.41 billion.

SAMHSA administers competitive, formula, and block grant programs; supports surveillance and data collection; and promotes best practices in behavior and public health. These program areas are administered by SAMHSA's Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Center for Behavioral Health Statistics and Quality (CBHSQ). SAMHSA also supports an Office of Policy, Planning and Innovation (OPPI).[178]

The existence of a specialized agency for substance abuse and mental health services indicates a fragmented and disjointed public health approach. The Centers for Disease Control and Prevention (CDC) exist to prevent and cure diseases of all kinds. According to the National Institute on Drug Abuse (NIDA), "Drug addiction is a preventable disease."[179] The vision statement for the National Institute of Mental Health's (NIMH) reads: "NIMH envisions a world in which mental illnesses are prevented and cured."[180]

CDC is currently engaged in extensive activities related to substance abuse and mental health. The mental health program at CDC seeks "To increase awareness of mental illness as an important public health problem and the importance of mental health promotion and mental illness prevention."[181] The program's goals include obtaining better scientific information, translating research into disease prevention programs, policies, and systems, and integrating mental health promotion, illness prevention and treatment with other disease prevention programs.[182]

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[176] "Reduce or Constrain Funding for the National Institutes of Health," REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS, Congressional Budget Office, March 2011; page 121; http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf .

[177] Based on the number provided in the report on how much NIH was awarded this year, $11,315,226, and the proposal's reduction recommendation.

[178] Department of Health and Human Services, 2012 Congressional Budget Justification for the Substance Abuse and Mental Health Services Administration, available at http://www.samhsa.gov/Budget/FY2012/SAMHSA-FY11CJ.pdf.

[179] National Institute on Drug Addicition, "NIDA InfoFacts: Understanding Drug Abuse and Addiction," http://www.drugabuse.gov/infofacts/understand.html

[180] National Institute of Mental Health Website, http://www.nimh.nih.gov/about/index.shtml , June 2010

[181] Centers for Disease Control and Prevention Website, http://www.cdc.gov/mentalhealth/about-us.htm, June 2010

[182] Centers for Disease Control and Prevention Website, http://www.cdc.gov/mentalhealth/about-us.htm, June 2010

CDC's substance abuse activities include extensive surveillance and activities related to infectious diseases spread through drug use.[183] Other CDC programs include alcohol and tobacco prevention and treatment activities.[184]

The entire SAMHSA agency should be folded into CDC in order to reduce duplication and establish a more appropriate and strategic public health approach to addiction and mental health disease. Consolidating these two agencies will save taxpayers significant funds –SAMHSA's salary and expenses totaled $342 million in 2011. Program management and evaluation savings can also be realized as the administrative responsibilities are assumed by CDC.

Consolidating SAMHSA with CDC does not need to be exceedingly complex. The four largest programs address all of the goals of SAMHSA and could subsume all other aspects of SAMHSA's authority and activities.

The Substance Abuse Block Grant Program, funded at $1.79 billion in 2011, provides formula funding to states based on need to address their individual state's substance abuse needs. Similarly, the $421 million *Mental Health Block Grant Program* similarly allows states to meet the particular mental health needs of their state.[185]

The Priority Substance Abuse Treatment Needs of Regional and National Significance (PRNS) and PRNS Mental Health funding streams -- totaling roughly $452 million in 2010 -- provide SAMHSA general authority to provide grants and fund activities to improve knowledge on best practices, provide training and technical assistance, and increase capacity of states and local entities to provide substance abuse treatment services.[186]

Many of the smaller programs eliminated in this section are duplicative of the broader block grant programs and do not receive enough funding to make a difference. For example, there is no need to provide funding separately to states for substance abuse treatment services for children and adolescents parallel to broader funding streams providing funding for substance abuse treatment priorities for each particular state.

Other programs administered by SAMHSA are duplicative of work being done by other government agencies. The following examples are just a sampling:

- *Grants for the Benefit of Homeless Individuals ($42.75 million).*[187] This program provides grants to develop and expand mental health and substance abuse treatment

[183] Centers for Disease Control and Prevention Website, http://www.cdc.gov/pwud/Default.html, June 2010
[184] Centers for Disease Control and Prevention Website, http://www.cdc.gov/alcohol/ and Centers for Disease Control and Prevention Website, http://www.cdc.gov/tobacco/, June 2010
[185] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search
[186] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.
[187] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.

services to homeless individuals. Funds are prioritized to grantees that have "experience in providing housing for individuals who are homeless."[188] The Department of Housing and Urban Development provides extensive federal funding for housing services to the homeless, particularly those with mental health needs and substance abuse problems.

- *Youth Suicide Early Intervention and Prevention Strategies (State Grants) ($29.7 million).*[189] This state grant program provides funding to public and nonprofit private entities to establish programs to reduce suicide deaths in the United States among children and adolescents. The Centers for Disease Control and Prevention already conduct very elaborate youth suicide prevention efforts.[190]

- *Children and Violence ($94.3 million annually).*[191] SAMHSA's children and violence program requires SAMHSA to work with the Department of Justice and Department of Education to providing funding to local communities to assist children in dealing with violence. There is little need, however, for SAMHSA to run a separate program. The Department of Justice administers multiple programs related to children and violence, including the "Children and Youth Exposed to Violence Grant Program," which funds projects that seek to mitigate the effects of domestic violence, dating violence, sexual assault, and stalking on children and youth exposed to violence and reduce the risk of future victimization or perpetration of domestic violence, dating violence, sexual assault, and stalking."[192] The Department of Education funds the Safe Schools/Healthy Students program for similar purposes.[193]

- *Protection and Advocacy for Individuals with Mental Illness Act ($36.4 million annually).*[194] The Department of Justice houses an entire Bureau of Justice Assistance that administers a Mental Health Courts Program.[195]

- *Center of Excellence on Services for Individuals with Fetal Alcohol Spectrum Disorders (FASD) ($9.8 million annually).*[196] The FASD Center for Excellence was created in 2001 to research FASD prevention, treatment, and care. At NIH, the National Institute

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[188] "Children's Health Act of 2000", Substances Abuse and Mental Health Administration, 2000, http://www.samhsa.gov/legislate/Sept01/childhealth_title32.htm

[189] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.

[190] "Preventing Suicide", Center for Disease Control and Prevention, September 2010, http://www.cdc.gov/ncipc/dvp/Preventing_Suicide.pdf,

[191] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.

[192] United States Department of Justice Website, http://www.ovw.usdoj.gov/ovwgrantprograms.htm#2, June 2010

[193] United States Department of Education Website, http://www2.ed.gov/programs/dvpsafeschools/index.html, June 2010

[194] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.

[195] Bureau of Justice Assistance Website, http://www.ojp.usdoj.gov/BJA/grant/mentalhealth.html, June 2010

[196] CRS Report Number: R41477, "Substances Abuse and Mental Health Administration : Agency Overview and Reauthorization Issues", Congressional Research Service, November 4th, 2010, http://www.crs.gov/pages/Reports.aspx?PRODCODE=R41477&Source=search.

on Alcohol Abuse and Alcoholism receives $462 million annually to provide much more intricate and dedicated research on this subject.[197]

There are also dozens of programs authorized in law under SAMHSA that do not receive funding and should be eliminated. In total, SAMHSA maintains over 30 programs not receiving appropriations in 2011.

SAVINGS:
By consolidating SAMHSA activities into the four core programs and further consolidating the agency with the Centers for Disease Control and Prevention, taxpayers can realize savings of approximately $4 billion over 10 years.

PROGRAMS ELIMINATED (31):

- Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances ($121.3 million annually)
- Children and Violence ($94.3 million annually)
- Program Management; SEH Workers' Compensation Fund ($79.2 million annually)
- PATH Grants to States ($65 million)
- Grants to Address the Problems of Persons Who Experience Violence and Related Stress. (Child Traumatic Stress Initiative ($41 million annually)
- Grants for the Benefit of Homeless Individuals ($42.75 million)
- Substance Abuse Treatment Services for Children and Adolescents ($31 million annually)
- Protection and Advocacy for Individuals with Mental Illness Act ($36.4 million annually)
- Youth Suicide Early Intervention and Prevention Strategies (State Grants) ($29.7 million)
- Residential Treatment Programs for Pregnant and Postpartum Women ($16 million annually)
- Center of Excellence on Services for Individuals with Fetal Alcohol Syndrome and Alcohol-Related Birth Defects and Treatment for Individuals with Such Conditions and their families ($9.8 million annually)
- Grants for Jail Diversion Programs ($6.7 million annually)
- Programs to Reduce Underage Drinking ($7 million annually)
- Mental and Behavioral Health Services on Campus ($5 million annually)
- Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans (N/A)
- Grants for Ecstasy and Other Club Drugs Abuse Prevention (N/A)
- Early Intervention Services For Children and Adolescents (N/A)
- Methamphetamine and Amphetamine Treatment Initiative (N/A)
- Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth (N/A)
- Services for Children of Substance Abusers (N/A)
- Grants for Strengthening Families (N/A)

[197] National Institute on Alcohol Abuse and Alcoholism, "FY 2012 Justification Budget", http://www.niaaa.nih.gov/AboutNIAAA/CongressionalInformation/Budget/Pages/FY12CJ.aspx

- Services for Individuals with Fetal Alcohol Syndrome (N/A)
- Prevention of Methamphetamine Abuse and Addiction (N/A)
- Youth Interagency Research, Training, and Technical Assistance Centers (N/A)
- Services for Youth Offenders (N/A)
- Suicide Prevention For Children and Adolescents (N/A)
- Centers for Emergency Mental Health Centers (N/A)
- Improving Outcomes for Children and Adolescents Through Services Integration Between Child Welfare and Mental Health Services (N/A)
- Grants for the Integrated Treatment of Serious Mental Illness and Co-Occurring Substance Abuse (N/A)
- Mental Health Training Grants (N/A)
- Data Infrastructure Development (N/A)

OTHER SAVINGS ASSOCIATED WITH AGENCY CONSOLIDATION

- Salary and Expenses ($342 million annually)
- Decrease in Rental Payments ($7 million annually)
- Reduction in Operation and Maintenance of Facilities ($1.3 million annually)
- General Decrease in Contractual Services ($100 million annually)

End Taxpayer Subsidies to The Institute of Medicine

The Institute of Medicine (IOM) is a non-governmental, nonprofit organization that says its purpose is to work "outside of government to provide unbiased and authoritative advice to decision makers and the public."[198] As the health division of the National Academy of Sciences, this sounds like a noble organizational mission. There's only one problem: federal taxpayers are heavily subsidizing this organization that duplicates the work of other organizations, with little benefit to taxpayers.

According to records obtained by the Congressional Research Service, during the last ten years, the IOM benefitted from $196 million dollars in federal funds just from the Department of Health and Human Services (HHS), or nearly two thirds of the National Academies' entire $307 million subsidization from federal taxpayers over a decade.[199] While the mission of the IOM and the motivations of its employees may be laudable, with taxpayers heavily subsidizing their business model, one can hardly call them "an independent, nonprofit organization that works outside of government."[200]

For all the money the federal government may be sending to IOM, taxpayers are not necessarily getting a good deal. Many of IOM's projects and reports duplicate the capabilities of other

[198]Institute of Medicine Website, "About IOM", http://www.iom.edu/About-IOM.aspx, July 7th, 2011
[199] Data provided to Office of Senator Tom Coburn, M.D. by Congressional Research Service.
[200] Institute of Medicine Website, "About IOM", http://www.iom.edu/About-IOM.aspx, July 7th, 2011.

organizations in and outside of government. For example, virtually all Departments within the federal government have employees who serve as policy analysts, budget crunchers, and issue experts that could be utilized in-house to produce reports or conduct research, at no extra cost to taxpayers. When issue expertise outside of government is truly needed, certainly our country has many other organizations that could provide insight and evaluation.

But it's not just the staff functions that IOM duplicates when compared to other federal resources –it's the tasks and assignments as well. A large number of IOM's mandates from federal agencies include analyzing an issue, producing a report, or conducting a study that duplicates work already being done elsewhere inside the government. An example of this is the IOM's Food Forum. The Food Forum defines itself as a group that, "discusses food-related topics ranging from risk assessment to aspects of consumer behavior."[201] The government already funds 15 food safety programs according to a recent GAO report. [202] FDA and USDA oversee a number of federal nutrition efforts and monitor the safety of consumer foods. The United States government spent $ 1.6 billion alone in 2009 on just three USDA or FDA programs. [203] The Food Forum is duplicative. The way forward, as GAO suggests, is not Congress simply funding another study or creating another program, but Congress conducting stronger oversight and requiring better coordination between existing programs.[204]

Certainly, many taxpayers may be disappointed to learn their hard-earned taxpayer dollars were used to fund the IOM's study of seafood in a human diet – a research assignment that likely overlaps with existing private sector endeavors, as well as National Science Foundation or USDA grants.[205] There are many intellectually interesting questions in science, and some are truly scientifically significant, but not all interesting questions are worthy of receiving taxpayer support. Other taxpayer-funded endeavors simply are not a national federal policy priority. For example, their report, "Strategies to Reduce Sodium Intake in the United States" can be summed up rather simply: encourage the consumption of less salt.[206]

Undoubtedly, many of the individuals serving at the IOM, and bureaucrats or politicians giving them grants, mean well. But in a time of dangerously high national debt, tough choices must be made about reducing federal spending, and federal taxpayers should not be forced to subsidize efforts that are duplicative and of questionable utility. Rather, program administrators and lawmakers should leverage the intellectual resources already within the federal government to tap experts with which research and analysis is needed. This common-sense step would save that money and begin better communication between agencies to help ensure not only the physical

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[201] "Nutritional Assessment Perspectives, Methods, and Data Challenges, Workshop Summary", Institute of Medicine, March 2007, http://www.nap.edu/catalog/11940.html; Woteki, Catherine and Buchanan, Robert, Presenters. U.S. National Library of Medicine, National Institutes of Health. http://www.ncbi.nlm.nih.gov/books/NBK37541/

[202] "Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue", Government Accountability Office, March 2011, http://www.gao.gov/new.items/d11318sp.pdf , pg 8.

[203] "Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue", Government Accountability Office, March 2011, http://www.gao.gov/new.items/d11318sp.pdf , pg 8.

[204] "Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue", Government Accountability Office, March 2011, http://www.gao.gov/new.items/d11318sp.pdf , pg 8.

[205] Institute of Medicine Website, "Nutrient Relationships In Seafood: Selections To Balance Benefits And Risks," July 7, 2011, http://www.iom.edu/Activities/Nutrition/Seafood.aspx.

[206] Institute of Medicine Website, "Strategies to Reduce Sodium Intake in the United States," July 7, 2011, http://www.iom.edu/Reports/2010/Strategies-to-Reduce-Sodium-Intake-in-the-United-States.aspx.

wellbeing of Americans, but their fiscal wellbeing as well, saving approximately $200 million over 10 years if HHS-funded projects alone were eliminated, or more than $300 million if all taxpayer-funding were ended.[207]

The Agency for Health Research and Quality

The Agency for Health Research and Quality (AHRQ) is one of 12 agencies within the Department of Health and Human Services (HHS). The agency states its mission is "to improve the quality, safety, efficiency, and effectiveness of health care for all Americans."[208] While this mission is certainly a praiseworthy goal, merely outlining a good goal does not ensure an effective federal agency or good use of taxpayer dollars. In fact, there are good reasons for taxpayers to be concerned that AHRQ has lost focus and may be wasting precious taxpayer dollars. The agency needs to be recalibrated and refocused so taxpayers' dollars are saved and AHRQ better serves the American people.

AHRQ has evolved from a series of agencies that were intended to encourage health research and health care technology assessment. In the late 1990s, President Clinton signed a law that gave AHRQ its current name and reauthorized the agency through FY2005. That was the last time Congress formally approved the program, reestablishing it and focusing its purpose.

Since the late 1990s, AHRQ has effectively pulled its entire annual budget from funds spread across several federal programs. Four public health service agencies –CDC, HRSA, NIH, and SAMHSA—are subject to having a portions of their budget tapped and set aside for other purposes. Current law authorizes HHS to redistribute a portion of this "set-aside" funding for other federal health programs – and each year, AHRQ gets enough funding to make it through to the following year. This may be a clever federal funding mechanism, but it may have in some ways enabled Congress to more easily ignore AHRQ, failing to examine whether or not programs were effective, efficient, or delivered good return on investment for taxpayers.

Unfortunately, many activities of the agency are unnecessary, duplicative, or even wasteful. For example, this year alone, AHRQ spent $143 million on comparative effectiveness research.[209] This waste of taxpayer dollars is part of the failed Stimulus that appropriated $1.1 billion to HHS for such research. [210]

In general, comparative effectiveness research (CER) is research that evaluates the effectiveness of different clinical interventions and strategies to prevent, diagnose, treat, and monitor medical conditions. When conducted in the private sector, CER is helpful to health care providers, as it informs their professional judgment and keeps them updated on scientific breakthroughs. Many private organizations are already engaged in high quality longitudinal, comparative research studies. For example, the Mayo Clinic, Consumer Reports, and professional medical societies all conduct various types of CER.

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[207] Special thanks to Robert Paulsen for his research assistance for this project.
[208] AHRQ Website, "Mission & Budget," http://www.ahrq.gov/about/budgtix.htm#background.
[209] "U.S. Department of Health and Human Services FY 2012 Budget", U.S. Department of Health and Human Services, 2011, http://www.hhs.gov/about/FY2012budget/cj2012_revised.pdf, pg. 12
[210] "U.S. Department of Health and Human Services FY 2012 Budget", U.S. Department of Health and Human Services, 2011, http://www.hhs.gov/about/FY2012budget/cj2012_revised.pdf, pg. 12

More troubling, however, is government-funded CER. Government-funded CER is not only duplicative of the efforts of a myriad of medical societies and health care organizations in this country, it is a slippery slope toward government-funded studies that evolve into government-mandating particular coverage decisions based *not* on what is most *clinically* effective for an individual patient, but what is most *cost*-effective for a budget.

AHRQ funds research that could be used to make decisions based on *cost* –not based on what is best for individual patient *care*.

This focus of a global budget at the expense of a patient is a real threat. Other countries have already used cost-based CER to make coverage decisions, reducing patient choices and limiting the ability of physicians to practice medicine. For example, in England, when Britain established their National Institute of Comparative Effectiveness (NICE), *The Guardian* reported in 1998: "Health ministers are setting up [NICE], designed to ensure that every treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere."[211]

Today, few would argue that NICE is anything but a rationing board, constantly making coverage decisions based on costs – not what is based on an individual patient need. There is not sufficient space in this report to re-litigate many of the concerns with government-funded CER, but often supporters of government-funded CER insist CER in AHRQ is merely providing "consumer reports" or "clinical best practices" to more health providers. This not only cloaks the intent of some, but it is clearly duplicative of the existing efforts at AHRQ. Health care providers can access the results of this private sector CER in medical society publications and through a National Guideline Clearinghouse website AHRQ maintains: www.guidelines.gov. The NGC, created by AHRQ, allows users to search for guidelines by disease, specialty, or condition. The Index contains 2,550 individual summaries of different guidelines that have been put out by dozens of medical societies.[212]

This model highlights the differences between the late 1990s and today. The digital explosion has brought the world closer and accelerated the sharing of knowledge. Patients and providers that used to search stacks of clinical journals and books now can access the best resources with the click of a button. All of this highlights a way forward for reforming AHRQ: marshalling private sector resources through a simple website, and saving tens of millions of taxpayer dollars in the process.

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[211] Wall Street Journal, "Of NICE and Men," http://online.wsj.com/article/SB124692973435303415.html.
[212] AHRQ Website, "Guideline Index," http://www.guidelines.gov/browse/index.aspx?alpha=A.

Another area for taxpayers to save money is in health information technology (health IT). The agency spent $27.6 million on health IT this year, despite a range of evidence that calls into question the cost-effectiveness of widespread health information technology. [213] The problems with government-funded health information technology are addressed more fully elsewhere in this proposal, but it's worth noting that as late as 2008, AHRQ could not demonstrate any results from its health IT programs.[214] Most tellingly, the nonpartisan Congressional Budget Office has found that massive federal spending on health IT is not necessary for its widespread adoption. [215]

AHRQ funds research on the medical benefits of meditation.

Taxpayers can also see savings by reducing AHRQ's administrative costs. Just this year, AHRQ spent $67 M on salaries and overhead costs – a whopping 17% of its annual budget.[216] With 300 employees, that's a whopping $223,000 per capita employee cost, at a time when the average family in American earns less than a quarter of that amount.

Unfortunately, millions of dollars went to the U.S. Preventative Services Task Force. The Task Force is the government panel that issued a recommendation in 2009 that women ages 40-49 were no longer encouraged to get routine mammograms. Further, the Task Force recommended that doctors do not teach patients how to do a self breast exam—stating that self-breast exams are not an evidenced-based preventive service. [217] Unfortunately, Congress's unpopular and controversial health care law depends on the advice and recommendations of the United States Preventive Services Task in several different instances – even forcing health insurance companies to cover all top priority recommendations, regardless of cost or effectiveness.[218] Disempowering this panel of unelected technocrats would save taxpayers millions of dollars and remove the undue influence this panel has on all Americans.

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[213] "U.S. Department of Health and Human Services FY 2012 Budget", U.S. Department of Health and Human Services, 2011, http://www.hhs.gov/about/FY2012budget/cj2012_revised.pdf, pg. 12

[214] Archived ExpectMore.gov website from 2009, Programs under the Department of Health and Human Services, http://georgewbush-whitehouse.archives.gov/omb/expectmore/agency/009.html accessed July 2011

215 Congressional Budget Office, 2009. "Estimated Effect on Direct Spending and Revenues of Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5): Health Information Technology." http://www.cbo.gov/ftpdocs/101xx/doc10106/health1.pdf

[216] "U.S. Department of Health and Human Services FY 2012 Budget", U.S. Department of Health and Human Services, 2011 http://www.hhs.gov/about/FY2012budget/cj2012_revised.pdf, page 70

[217] Senator Coburn Website, "Majority's Health Bill Empowers Government Task Force At Center of Mammogram Controversy", June 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=7aa9e6ff-331a-48a6-abb3-c7df4bd8d199

[218] Senator Coburn Website, "Majority's Health Bill Empowers Government Task Force At Center of Mammogram Controversy", June 2010, http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=7aa9e6ff-331a-48a6-abb3-c7df4bd8d199

This year AHRQ announced it spent $1,059,000 for a contract with an advertising agency in New York City for a year-long campaign featuring TV, radio, print, Web, and outdoor ads. According to AHRQ, the purpose of the ad campaign is to "encourage patients to be more involved in their health care and empowered to make shared decisions about their treatment with their providers."[219] In a digital age when consumers can search for an abundance of clinical information online, a million-dollar ad campaign is unnecessary to inform Americans about their treatment choices. In fact, according to a Pew Forum internet study released earlier this year, "Four in five Internet users have searched the Web for health care information, most often checking on specific diseases and treatments."[220] In fact, "Eight in ten internet users look online for health information, making it the third most popular online pursuit" among those tracked by project.

Finally, some AHRQ program dollars could be taken from wasteful grant programs and redirected toward cancer research at the National Institutes of Health. This certainly would be a better use of taxpayer dollars than some grants AHRQ has funded on dubious topics like an analysis of meditation techniques, or the total number of emergency room visits resulting from dog bites.[221] These endeavors are not a national priority and in a time of dangerously high debt, make poor use of taxpayer dollars. AHRQ should be carefully targeted taxpayer dollars, not supporting grants with self-evident findings that conclude "Lower health literacy linked to higher risk of death."[222]

Given AHRQ's outdated focus, wasteful spending, misaligned priorities, and duplication of private sector efforts, by recalibrating AHRQ's mission and trimming its budget by three-fourths taxpayers would save more than $4 billion over a decade.

End Federal Subsidies for Health Information Technology

A provision of the 2009 failed Stimulus law (American Recovery and Reinvestment Act) massively expanded the federal government's role in health information technology. The aims many attribute to the Health Information Technology for Economic and Clinical Health (HITECH) Act sound good: using a variety of policy levers to promote the widespread adoption of health information technology and support digital sharing of clinical data among hospitals, physicians, and other health care stakeholders. However, a closer look at the data shows that Congressional action was the wrong mechanism to accomplish these goals.

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[219] Freudenheim, Milt. "Health Care Is High Among Web Searches," The New York Times, February 1, 2007. http://prescriptions.blogs.nytimes.com/2011/02/01/health-care-is-high-among-web-searches/

[220] Fox, Susannah. Associate Director, Pew Research Center's Internet & American Life Project, "80% of internet users look for health information online," February 1, 2011. http://pewinternet.org/~/media//Files/Reports/2011/PIP_HealthTopics.pdf

[221] Agency for Healthcare and Research Quality Website, http://www.ahrq.gov/downloads/pub/evidence/pdf/meditation/medit.pdf, July 2011 ; "Health Care Cost and Utilization Projection", Agency for Healthcare and Research Quality Website, July 2011 http://www.hcup-us.ahrq.gov/reports/statbriefs/sb101.pdf

[222] "Low Health Literacy Linked to Higher Risk of Death and More Emergency Room Visits and Hospitalizations", Agency of Healthcare and Research Quality, July 2011, http://www.ahrq.gov/news/press/pr2011/lowhlitpr.htm

Lawmakers in Congress may have been well-intended when they supported the HITECH Act, but the massive federal intrusion into health information technology is wasteful and duplicative of current business practices. According to the nonpartisan Congressional Budget Office, the use of health information technology was already projected to be widespread by the end of the decade – even *without the adoption of the HITECH Act*. CBO projected that, without the HITECH Act, two-thirds of physicians, approximately half of hospitals, and at least one in five critical access hospitals would still be robustly using health IT by the end of the decade.[223]

Some reports have suggested private sector health information technology in a multi-year period is far more than the federal government is projected to spend on health IT over the next decade. In fact, in a recent survey, more than half of respondents replied they have a fully operational electronic health record in at least one facility in their organization, and only 1 in 50 respondents had not yet begun to plan for the use of an EHR.[224] The facts make it pretty clear that massive federal handouts and mandates are unnecessary to subsidize a behavior that is already being adopted on a widespread basis in the marketplace.

Additionally, the private sector has already developed compelling models for utilizing health information technology. Major health systems like the Mayo Clinic and the Cleveland Clinic all have adopted state-of-the-art health IT systems—without federal involvement. Private enterprises are leading the way in developing completely innovative approaches to health IT. Some are even exploring the development of open software for innovators to write electronic health record applications. Such an "open source" model could help increase competition, flexibility and lower costs – all without federal action.

Certainly, health information technology is a helpful tool for physicians and other providers, but massive federal mandates, layers of red tape, and subsidies are not a policy panacea. Physicians and other health care providers already have to comply with thousands of pages of federal regulations, laws, and guidelines under the Medicare and Medicaid programs, HIPPA privacy standards, and other mandates. Under the law, now physicians and hospitals that are not using government-approved electronic health records will soon face financial penalties for their non-compliance. All of these requirements add to a physician's overhead expenses and paperwork – many without directly improving patient care or outcomes. Unfortunately, the burden of new mandates falls disproportionately on smaller physician practices – many of whom provide critical access for patients in rural communities. According to the Center for Health Care Strategies, approximate 60% of physicians serve in practices less than five physicians, and

[223] Congressional Budget Office, "Estimated Effect on Direct Spending and Revenues of Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5): Health Information Technology," http://cbo.gov/ftpdocs/101xx/doc10106/health1.pdf.
[224] 2011 HIMSS Leadership Survey (executive summary)

roughly two-thirds of all physician visits take place at these small practices.[225] Little wonder then, that a survey of 500 physicians recently showed that a decreasing number of physicians say that the financial benefits of electronic medical records outweigh the costs.[226] In fact, as the *Wall Street Journal* explained, the findings from the annual survey also noted physicians "were less likely to agree that electronic records can help reduce medical errors, improve efficiency and lower costs. And a greater proportion of physicians said electronic records slow them down and don't achieve a measurable financial impact."[227]

Small physician practices are not the only ones who may be doubtful about the cost-effectiveness of health IT adoption either. Before the HITECH bill was pushed through Congress, Reuters highlighted the results of a Harvard study of about 4,000 hospitals that "found that while many had moved away from the paper files that still dominate the U.S. healthcare system, administrative costs actually rose, even among the most high-tech institutions."[228] In fact, Dr. David Himmelstein, a Harvard medical school professor who led the study, indicated that while digitization may have some marginal effects to improve quality, the investment does not make sense from a financial perspective. "Our study finds that hospital computerization hasn't saved a dime, nor has it improved administrative efficiency," Himmelstein said, emphasizing that "Claims that health IT will slash costs and help pay for the reforms being debated in Congress are wishful thinking." [229]

Many have also expressed the concern that federal intrusion into the health information technology sector may have a distorting effect – artificially propping up some technologies, while discouraging others – rather than letting market forces of provider choice and supplier competition drive value for consumers and providers. It certainly is worrisome that the federal government may be effectively rewarding a particular technology or business model over another, picking winners and losers. Two Harvard professors took to the pages of *The New England Journal of Medicine* to underscore that currently available health IT systems are costly and are wedded to proprietary technology standards.[230] This makes it difficult for customers to switch vendors or for outside programmers to make improvements. "If the government's money goes to cement the current technology in place…we will have a very hard time innovating in health care," says Dr. Mandl of Harvard Medical School. Rather than rely on any one approach,

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[225] Ackerman, Kate, "When It Comes to EHR Adoption, Practice Size Matters," IHealthBeat, http://www.ihealthbeat.org/features/2011/when-it-comes-to-ehr-adoption-practice-size-matters.aspx.
[226] Athena Health Website, "2011 Physician Sentiment Index: Taking the Pulse of the Physician Community," http://www.athenahealth.com/index.php?open=26.
[227] Hobson, Katherine, "Physicians More Skeptical of Electronic Medical Records.," Wall Street Journal, http://blogs.wsj.com/health/2011/02/23/physicians-more-skeptical-of-electronic-medical-records/?mod=WSJBlog&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+wsj%2Fhealth%2Ffeed+%28WSJ.com%3A+Health+Blog%29.
[228] Heavey, Susan, "No hospital savings with electronic records: study," Reuters, http://www.reuters.com/article/2009/11/20/us-usa-healthcare-healthit-idUSTRE5AJ0MQ20091120.
[229] Heavey, Susan, "No hospital savings with electronic records: study," Reuters, http://www.reuters.com/article/2009/11/20/us-usa-healthcare-healthit-idUSTRE5AJ0MQ20091120.
[230] No Small Change for the Health Information Economy, http://content.nejm.org/cgi/content/full/360/13/1278

we need to focus on interoperability standards so that competing systems can "talk to each other."[231]

However, while interoperability is an important goal, there remain significant challenges to ensuring technological platforms are interoperable in a manner that allows accurate, secure data transfer and clinical integration. A study of 179 regional health information organizations –that facilitate the health information exchanges needed to share data– found that regional health information organizations are fully operational in less than 15% of hospitals so far. [232] As the study's authors note, "these findings call into question whether [regional health information organizations] in their current form can be self-sustaining and effective in helping U.S. physicians and hospitals engage in robust [health information organizations] to improve the quality and efficiency of care." [233]

Finally, at a time when more and more Americans may feel vulnerable to their digitized information being shared online without their knowledge, there remain significant security challenges for the health IT industry to sort through. According to a recent survey of health IT professionals, their primary concern continues to be a security breach of their organization's data. [234] Their concern is well placed since about one in four respondents in the same survey said their organization has experienced a breach of security in the past year alone. [235] Unfortunately, the federal agencies charged with administering and overseeing the HITECH Act do not have a much better record. A recent news report highlighted two audits released by the Department of Health and Human Services' Office of Inspector General (OIG) that found "federal agencies charged with building a secure health information technology infrastructure are not doing enough to implement the proper security measures needed to protect sensitive patient information."[236] The news coverage characterized the OIG findings as providing a "sobering view of the federal government's efforts to keep computerized patient data secure at a time when billions of dollars are being spent on incentive programs that will accelerate the adoption of electronic health records." [237] The OIG examined the Medicare program's work and found that its oversight and enforcement actions were not sufficient to ensure provider compliance with patient protections.[238] One might rightly question how the Medicare program can administer new programs and implement mandates if it cannot effectively administer long-standing programs well.

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[231] Lohr, Steve. "Doctors Raise Doubts on Digital Data," *New York Times,* March 25, 2009. http://www.nytimes.com/2009/03/26/business/26health.html

[232] Annals of Internal Medicine, "A Survey of Health Information Exchange Organizations in the United States: Implications for Meaningful Use," July 2011, http://www.annals.org/content/154/10/666.short?rss=1.

[233] Annals of Internal Medicine, "A Survey of Health Information Exchange Organizations in the United States: Implications for Meaningful Use," July 2011, http://www.annals.org/content/154/10/666.short?rss=1.

[234] 2011 HIMSS Leadership Survey (executive summary)

[235] 2011 HIMSS Leadership Survey (executive summary)

[236] Lewis, Nicole, "Federal Agencies Fail Health IT Security Audits," Information Week, July 2011, http://www.informationweek.com/news/healthcare/security-privacy/229502471.

[237] Lewis, Nicole, "Federal Agencies Fail Health IT Security Audits," Information Week, July 2011, http://www.informationweek.com/news/healthcare/security-privacy/229502471.

[238] Office of Inspector General:Audit (A-04-08-05069), "Nationwide Rollup Review of the Centers for Medicare & Medicaid Services Health Insurance Portability and Accountability Act of 1996 Oversight," http://oig.hhs.gov/oas/reports/region4/40805069.asp.

Congress may have had high hopes for the HITECH Act when it was passed as part of the Stimulus, but it unfortunately shares an ignoble theme with the Stimulus: failed and wasteful federal government spending that has produced virtually no demonstrable results. There remain significant health IT issues the health care community is working through, but the private sector is the right place for these discussions and innovations to occur. This proposal repeals the federal health information technology mandates and subsidies, saving taxpayers $15.6 billion through 2019.

Make Food Safety Changes at the Food and Drug Administration

The Food and Drug Administration (FDA) is a regulatory agency within the Department of Health and Human Services (HHS). FDA primarily regulates foods, drugs, devices, and tobacco. FDA received $3.3 billion in FY2011. [239]

Recently, FDA has come under scrutiny for its failure to prevent recent food borne illness outbreaks. Congress recently passed the Food Safety Modernization Act of 2010 in an attempt to modernize the agency and prevent future food safety scares. The new legislation authorized $1.4 billion in new spending on food safety efforts, which would grow the entire agency by nearly 50 percent.[240]

The FDA drug and device approval process and regulatory framework needs to be significantly improved to increase innovation and access to life saving and improving treatments and cures. While there may not be significant direct savings for taxpayers in these areas, Congress and the Administration owe it to American patients to fix what ails our broken drug and device regulatory regime to lower costs and improve health outcomes.

There are, however, significant savings to be had by streamlining FDA food safety efforts, which currently cost the federal government. The FDA Foods Program regulates $417 billion worth of domestic food, $49 billion worth of imported foods, and $62 billion worth of cosmetics. FDA is tasked with regulating 167,000 registered domestic food establishments, 254,000 foreign facilities, and more than 3,500 cosmetic firms. FDA is responsible for many, but not all, food products (USDA regulates meat, poultry, and frozen, dried, and liquid eggs).[241]

Duplicative and Disjointed Government Approach to Food Safety. In 2008, GAO testified before a House subcommittee that "FDA is one of 15 agencies that collectively administer at least 30 laws related to food safety. This fragmentation is the key reason GAO added the federal

[239] "Budget in Brief," U.S. Department of Health and Human Services, http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf
[240] Based on data from the Congressional Research Service.
[241] Food and Drug Administration, "FDA Budget", Food and Drug Administration U.S. Department of Health and Human Services, http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/BudgetReports/UCM243370.pdf

oversight of food safety to its High-Risk Series in January 2007 and called for a government wide reexamination of the food safety system. We have reported on problems with this system—including inconsistent oversight, ineffective coordination, and inefficient use of resources."[242]

Specifically, GAO found that in 2003, FDA and USDA activities included overlapping and duplicative inspections of 1,451 domestic food-processing facilities that produce foods regulated by both agencies. This GAO testimony came on the heels of a 2005 GAO report that identified significant overlap in food safety activities conducted by USDA and the FDA, and to some extent the EPA and National Marine Fisheries Service (NMFS), including "71 interagency agreements [to coordinate overlapping activities] that the agencies entered into… However, the agencies have weak mechanisms for tracking these agreements that…lead to ineffective implementation."[243]

This overlap was evident in the 2010 egg salmonella scare. The Wall Street Journal reported that U.S. Department of Agriculture experts knew about sanitary problems at one of the two Iowa farms at the center of a massive nationwide egg recall, but did not notify health authorities. USDA inspects farms and gives eggs their "Grade A" label, while the FDA technically is tasked with the safety of the final egg product. [244]

This discrepancy was the impetus behind an egg safety rule originally promulgated 10 years ago by the FDA. Unfortunately, three administrations sat on the proposed rule without finalizing and implementing it. FDA Commissioner Dr. Hamburg stated, "We believe that had these rules been in place at an earlier time, it would have very likely enabled us to identify the problems on this farm before this kind of outbreak occurred." [245]

Ineffective and Burdensome Regulations. FDA cites 24 separate laws providing their authority to regulate the American food supply. Yet, Congress was forced to pass new legislation in 2010 totaling 225 pages of new regulations. The FDA Foods Program is a weighty infrastructure placing a myriad of rules and requirements on American food producers.

Yet, as the over 2,000 people sickened by the salmonella outbreak in 2010 or the thousands more who became ill from the peanut and jalapeno scares in 2009 and 2008 respectively, it has become clear that federal food regulations are not protecting us from widespread food borne illnesses.

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[242] "Federal Oversight of Food Safety Activities: Summary", Government Accountability Office, March 2005, http://www.gao.gov/products/GAO-08-435T

[243] "Oversight of Food Safety Activities", Government Accountability Office, March 2005, www.gao.gov/new.items/d05213.pdf, page 25

[244] Hobson, Katherine, "USDA Saw Bugs and Trash at Egg Producer; Didn't Tell FDA", *Wall Street Journal*, September 10, 2010, http://blogs.wsj.com/health/2010/09/10/usda-graders-saw-bugs-and-trash-at-egg-producer-didnt-tell-fda/

[245] Senator Coburn Website, "Detailed Concerns with S. 510, the FDA Food Modernization Act", http://coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=8df5cb89-91a2-4ae3-b846-7487db0bd4f0, September 15, 2010

In the tomato scare, FDA inappropriately identified fresh tomatoes as the source of a contamination of roughly 1,300 Americans, despite the fact the cause was actually tainted jalapenos.[246] FDA's clear mistake led to $100 million in losses for the tomato industry. In 2009, the Peanut Corporation of America was forced to initiate one of the largest recalls in our nation's history, despite the fact their plant in Georgia had been inspected twice in recent years by Georgia inspectors that partnered with the FDA.[247]

The authors of the Food Safety Modernization Act, however, doubled-down on the government's failed approach to food safety. They believed that 225 pages of new federal regulations—many of which will be overly burdensome on industry and small providers—is the answer to what ails our food safety system. Burdensome regulations are a recipe for increased costs to taxpayers, industry, and consumers in the form of higher food prices. A different approach is necessary.

New Approach to Food Safety. FDA can help ensure safer food with far less resources if the agency takes a more strategic and less duplicative approach to food safety. Congress should immediately require FDA and USDA to establish a comprehensive plan to share information, clarify existing duplicative efforts, and issues a joint report to Congress with a plan to consolidate all food safety authority under one of these established agencies.

Even more importantly, FDA needs to begin leveraging existing free market food safety activities. The Congressional Research Service notes that the U.S. food supply is the safest in the world. Markets, not government, have made this happen. Our food supply is the safest in the world because—in America—the consumer has the ability to hold companies accountable for providing safe food and enjoys other viable choices in the marketplace.

Private companies update their food safety contracts constantly in an effort to incorporate the best and most up to date science. FDA should harness private third-party inspections and provide incentives to companies that demonstrate superior food safety efforts. FDA should be given the authority to take private inspections and private food safety contracts into account when setting their inspection schedules.

Instead of focusing on trying to regulate and inspect our way to food safety, FDA should also assume a more effective leadership role in promoting innovation in food safety. FDA should develop more expeditious ways of approving new food safety technologies and communicating the benefits of these innovations to industry and consumers. Much like pasteurization became a key mechanism to keep people safe, FDA can become a scientific leader in developing the next generation of food safety techniques.

[246] Based on general media coverage.
[247] Based on general media coverage.

By enacting these reforms to reorganize the FDA Foods Program and change their field activities, FDA can save at least $1.5 billion over the next 10 years.

Miscellaneous Reforms

Trim Taxpayer-Provided Subsidies to Federal Workers' Health Care. The Federal Employees Health Benefits (FEHB) program offers health insurance coverage to approximately 4 million federal employees and as well as to approximately 4 million of their dependents or survivors. According to the Congressional Budget Office (CBO), in 2011 these "benefits are expected to cost the government almost $41 billion."[248] Under current law, workers pay at least 25 percent of the premium, and federal taxpayers pay the remainder of the premium costs. CBO noted that under this cost-sharing arrangement, the incentive for beneficiaries paying their fair share is "less than it would be if employees realized the full savings from choosing a less expensive plan." [249]

By offering employees a voucher for the FEHB program that would cover the first $5,000 of an individual premium or the first $11,000 of a family premium in 2013 and letting workers bear more of the cost for choosing an expensive plan, taxpayers could see significant savings. In CBO's analysis of this estimate, they expected the voucher "would increase annually at the rate of inflation as measured by the consumer price index for all urban consumers, rather than at the average weighted rate of change in FEHB premiums." [250] CBO said this policy reform "would increase the incentive to choose lower-premium plans and would strengthen price competition among health care plans participating in the FEHB program." [251] They also noted that "insurers would have a greater incentive to offer lower-premium plans whose cost approached or matched that value." [252]

Allow Americans to Purchase Health Insurance In Any State. Unlike most other insurance products, under current law, Americans are prohibited from purchasing health insurance in a state other than the state in which they reside. Rather than face limited choices and be forced to purchase more expensive health coverage than they want, Americans should have the freedom to shop across state lines for their health insurance coverage. There is a sensible policy solution: permit an insurance carrier to choose one state in which to become licensed, and as long as the carrier's individual health insurance policies complied with the insurance laws and regulations of that state, the carrier would be permitted to sell those policies in other states and to be exempted from the laws and regulations of those other states.

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[248] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March, 2011. Option 14, pages 37-38. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf

[249] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March, 2011. Option 14, pages 37-38. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf

[250] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March, 2011. Option 14, pages 37-38. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf

[251] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March, 2011. Option 14, pages 37-38. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf

[252] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March, 2011. Option 14, pages 37-38. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf

According to the Congressional Budget Office (CBO), this policy "would have different effects depending on whether individuals were expected to spend a great deal or a small amount for health care and whether their own states' laws tightly or loosely restricted the rating and other features of health insurers' policies."[253] But the net effect CBO outlines is impressive: this policy change would reduce the number of the uninsured by 400,000.[254] This would happen because "individuals who had a low risk of incurring substantial health care costs and who lived in states that restricted insurers' ability to price plans on the basis of their relatively healthy status might find better priced health plans sold by out-of-state carriers." [255]

CBO also found that adopting this policy states with very constrictive and costly health insurance regulation "might consider loosening their regulations in an attempt to reduce premiums for healthy enrollees and to retain insurers." [256] This change could lower costs for consumers and increase their health coverage choices. There is good news for federal taxpayers as well, who could save more than $7 billion over a decade by adopting this policy.

Accomplish Meaningful Medical Malpractice Reform. In his State of the Union remarks to Congress earlier this year, President Obama said he was "willing to look at other ideas to bring down [health care] costs, including … medical malpractice reform to rein in frivolous lawsuits."[257] The President rightly identified a significant cost-driver in health care that must be addressed. Numerous surveys have demonstrated physicians and other health care providers often order unnecessary tests or treatments, out of a fear of later being sued by a patient for malpractice who claims a disease or condition was not diagnosed.

According to the Congressional Budget Office (CBO), "many analysts surmise that the current medical liability system encourages providers to increase the volume or intensity of the health care services they provide to protect themselves against possible lawsuits."[258] While the vast majority of physicians are cleared of any wrong-doing in medical malpractice cases, certainly, the current legal treatment of medical malpractice effectively encourages junk lawsuits that do not keep any one from getting sick or make any one get well.

The costs of higher malpractice insurance are a direct cost to our nation's health care system, but the indirect costs are real as well. Because many providers fear junk lawsuits, they often order

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[253] Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008. Option 2, "Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State," pages 9-10. http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf

[254] Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008. Option 2, "Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State," pages 9-10. http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf

255 Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008. Option 2, "Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State," pages 9-10, http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

256 Congressional Budget Office, "Budget Options, Volume I: Health Care," December 2008. Option 2, "Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State," pages 9-10. http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

[257] President Obama's State of the Union Address, January25, 2011. http://www.whitehouse.gov/the-press-office/2011/01/25/remarks-president-state-union-address

[258] Congressional Budget Office, Letter to Senator Orrin Hatch, October 9, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf

tests that may be duplicative or medically unnecessary. The costs of these unnecessary tests and treatments are passed throughout the health care system and born by patients in the manner of higher health insurance premiums.

CBO echoes this dynamic, saying: "tort reform could affect costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of diagnostic tests and other health care services when providers recommend those services principally to reduce their potential exposure to lawsuits."[259] To reduce costs to patients and system-costs, this proposal assumes a series of incentives and policy levers designed to accomplish state-based meaningful malpractice reform.

The changes, as envisioned by CBO, include: "(1) cap of $250,000 on awards for noneconomic damages; (2) cap on awards for punitive damages of $500,000 or two times the award for economic damages, whichever is greater; (3) modification of the "collateral source" rule to allow evidence of income from such sources as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries; (4) statute of limitations—one year for adults and three years for children—from the date of discovery of an injury; (5) replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury."[260]

At a time of high health care costs and unaffordable health coverage premiums, this is a common-sense step designed to lower costs to consumers. This change would also be good medicine for the health care community, as physicians and other providers would have realigned incentives to avoid unnecessary medical treatments. This proposal would ensure states adopt meaningful malpractice reforms, therefore saving taxpayers more than $54 billion over a decade.[261]

DEPARTMENT OF HEALTH AND HUMAN SERVICES TEN YEAR SAVINGS
Discretionary: $106.7 billion
Total: $106.7 billion

[259] Congressional Budget Office, Letter to Senator Orrin Hatch, October 9, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf
[260] Congressional Budget Office, Letter to Senator Orrin Hatch, October 9, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf. Numeration added for readability.
[261] Congressional Budget Office, Letter to Senator Orrin Hatch, October 9, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf. Numeration added for readability.